Coordination of Benefits Agreement (COBA)

Implementation User Guide

COBA004-3.0
05/2005

Contents

Coordination of Benefits Agreement (COBA) Implementation User Guide

Contents

Coordination of Benefits Agreement (COBA) Technical Implementation Guide

Coordination of Benefits Agreement (COBA)

OVERVIEW

Implementation User Guide

Overview

Coordination of Benefits Agreement (COBA) Technical Implementation Guide

OVERVIEW

The purpose of the COBA Implementation User Guide is to communicate directly with staff affiliated with each Trading Partner about the administrative, technical, and financial requirements for implementing the Coordination of Benefits Agreement (COBA). Emphasis is given to preparing and testing data files to and from the Coordination of Benefits Contractor (COBC). This guide includes five sections:

- **COBA PROGRAM:**

  This section introduces the Coordination of Benefits program—its goals and expected benefits. A checklist is provided to guide the Trading Partner through the steps required to implement the COB Agreement and its Attachment. Two timelines—one for the COBA program and one for Trading Partners—display the current schedule for the COBA program implementation.

- **COBA:**

  The section includes a description of the COBA, a glossary of 13 claims selection criteria, and a sample COBA Profile Report.

- **COBA TECHNICAL:**

  This section details the required process and formats for testing with current Eligibility and Claims File. Specifications for tape transfers and electronic transmissions are listed, and a chapter covers the required file formats and emphasizes that all COBA participants must use HIPAA-standard transactions and code sets rules for claims. Also, contained in this section is the necessary procedure that the Trading Partner will follow to contact the COBC in the event of a missing or indecipherable file. Other useful Web sites addresses pertaining to HIPAA transaction and code sets are also provided.

Overview

- **COBA FINANCIAL:**

  Trading Partners under the COBA program may choose billing and payment remittance options. This section provides a complete summary of COBC's Electronic Invoice Presentment and Payment System, how it works, and how to get started.

- **COBA CUSTOMER ASSISTANCE:**

  This section provides the appropriate addresses for submitting COBA correspondence and contact information for customer service representatives.

Coordination of Benefits Agreement (COBA)

COBA PROGRAM

Implementation User Guide

Coordination of Benefits Agreement (COBA)

Introduction to COBA

Implementation User Guide

Introduction to COBA

INTRODUCTION TO COBA

Background

Today, Medicare Contractors individually negotiate and execute crossover Trading Partner Agreements (TPAs) with other insurers and benefit programs—i.e., with Medigap plans, employer supplemental plans, Tricare for Life, and State Medicaid Agencies—that do business within their geographic jurisdiction for the electronic transfer of Medicare paid claims information. These TPAs are entered into on a voluntary basis.

The Centers for Medicare & Medicaid Services (CMS) recently developed a model national contract, called the Coordination of Benefits Agreement (COBA), for use in negotiating new and renegotiating existing local TPAs. COBAs will standardize the way that eligibility and Medicare claims payment information is exchanged. COBAs will permit other insurers and benefit programs to send eligibility information to and receive Medicare paid claims data for processing supplemental insurance benefits for Medicare beneficiaries from CMS' national crossover contractor, the Coordination of Benefits Contractor (COBC).

Purpose

The new COBA program establishes a uniform national contract between CMS and other health insurers and benefit programs. The COBA program also introduces a standard processing methodology across the national Medicare community. The COBA allows greater efficiency and simplification via consolidation.

Implementation of COBA means that other health insurers and benefit programs that are eligible to receive Medicare paid claims information from CMS for purposes of calculating their supplemental payment will no longer have to sign separate crossover agreements with individual Medicare Contractors. Moreover, they will no longer need to send separate eligibility files to individual Medicare Contractors and receive separate claims crossover files from Medicare Contractors. COBAs will allow other insurers and benefit programs to send eligibility information to and receive Medicare paid claims data, along with other coordination of benefits data, from one contractor, the COBC.

Coordination of
Benefits
Agreement
(COBA)

Implementation Checklist

Implementation
User Guide

Implementation Checklist

IMPLEMENTATION CHECKLIST

This checklist is designed to give you a clear overview of the COBA Implementation process and, at the same time, serve as a step-by-step guide to fulfilling the requirements of the COBA program. For further information, please refer to the Customer Assistance section in this guide.

Enrollment

- Contact the COBC. The Trading Partner may contact the COBC to discuss the COBA service options, which will be customized for its organization and specified in the COBA Attachment. The telephone number to call is (646) 458-6740.

- Execute COBA (s). Sign two original agreements. Upon receipt, the COBC will sign both originals and return one original to you for your records.

- Complete the Attachment. This form provides specific information to install your COBA such as what type of insurer or benefits program you represent, primary points of contact, and claims selection options.

- Forward each signed COBA and Attachment to the COBC at the mailing address specified in the Customer Assistance section in this guide and in Section II.B of the COBA Attachment.

- Obtain COBA Identification Number(s) from the COBC. Upon receipt and successful processing of your COBA and Attachment, the COBC will generate a Profile Report assigning your COBA ID(s).

- Notify the COBC of your approval of the Profile Report after reviewing it for accuracy. Follow the notification instructions accompanying the Profile Report.

Implementation Checklist

- Obtain the appropriate deinstallation procedures and lead times from Medicare intermediaries and carriers with whom you have existing agreements. It is the Trading Partner's responsibility to ensure that all current crossover Trading Partner Agreements (TPAs) are terminated prior to COBA implementation with the COBC. (Note: Each Trading Partner will continue to receive production crossover claims via the existing process while testing the COBA process with the COBC. All trading partners will participate in a parallel testing period and will individually move into production when CMS, the COBC, and these partners agree that should occur.) The test phase will commence upon full execution of the COBA.

Testing

- Set up connectivity test. Coordinate testing of two-way transmission capability with the COBC, if applicable (i.e., electronic transmissions).

- Obtain a test date from the COBC. Upon receipt of each signed COBA and Attachment, the COBC will provide you with the next available date to commence testing.

- Provide data transfer information. For tape transfer of COBA information, complete the Tape Transfer Form; otherwise, complete the Electronic Transmission Form contained in this guide. Return the form to the COBC as indicated in the Customer Assistance section of this guide.

- Create test eligibility file(s). Eligibility files must be generated in the required COBA Eligibility File Format using your assigned COBA ID(s) as furnished to you by the COBC. (Note: Parallel tests will normally be done with a full size production eligibility file; however, partial eligibility files may be used.)

Implementation Checklist

- Submit your test eligibility file(s) to the COBC. You may transmit your eligibility file(s) electronically or mail your test eligibility file(s) to the COBC. Refer to the mailing address specified in the Customer Assistance section in this guide. (Note: The eligibility test file will be loaded to the Beneficiary Other Insurance [BOI] file in CWF and testing will occur during the normal course of production.)

- Review your test eligibility results. The COBC will forward an Eligibility Detail Report that confirms receipt of an eligibility file; summarizes the number of records submitted; lists the number of adds, updates, and deletes; lists all eligibility errors, if any; and explains the reason for each error.

- Review test Claims File(s) from the COBC. The COBC will create and forward Claims Files in the required formats for all claims matching eligibility information and claims selection criteria.

- Sign off on the test process with the COBC. Once you are satisfied with the test results, call the COBC's EDI department and request a Test Sign-off Form. Follow the instructions as outlined on this form.

- Perform Financial Testing.

Final Implementation

- Obtain an implementation date from the COBC. Upon receipt of your Test Sign-off Form, the COBC will provide you with the next available date to implement your COBA (s).

- Terminate existing TPAs. Notify Medicare intermediaries and carriers of your COBA implementation date. It is the Trading Partner's responsibility to ensure that **all** current agreements are terminated, or as applicable amended, prior to COBA implementation with the COBC.

- Create and submit production eligibility file(s) to the COBC.

Review and follow instructions as provided in the Finance section of this guide for billing and payment remittance.

Coordination of Benefits Agreement (COBA)

Implementation Timeline

Implementation User Guide

Implementation Timeline

IMPLEMENTATION TIMELINE

COBA Program Timeline

The CMS commenced testing of the Coordination of Benefits Agreement (COBA) technical operations with a small group of trading partners (a pilot) prior to full-scale implementation of the consolidation of the claim crossover process. The COBA beta testing period began on July 6. This has given CMS, the COBC, and the Trading Partner an opportunity to thoroughly test the planned technical operations—most particularly testing of the receipt and acceptance of 837 HIPAA COB claim files—for the COBA initiative.

Beginning no earlier than April 2005, trading partners will be transitioned from their current crossover process with individual Medicare contractors to the COBA consolidated process.

COBA Trading Partner Timeline

The following list the major milestones and estimated durations in implementing the COBA Program with the COBC noted in business days:

Task	Estimated Duration
Negotiate and execute COBA	15 days
Receive COBA ID(s), approve Profile Report, and begin data transfer setup.*	7 days
Generate mini and full test eligibility file(s)	15 days
Review test claims files, complete financial testing, and provide test sign-off	25 - 40 days
Termination of existing agreements	15 days
Total Estimated Duration	77 - 92 days

*Note: The timeframe listed applies if trading partners already have connectivity with Medicare. If trading partners do not already have connectivity with Medicare, the set-up process may take 60 days.

Coordination of
Benefits
Agreement
(COBA)

COBA

Implementation User Guide

Coordination of Benefits Agreement (COBA)

COB Agreement and Attachment

Implementation User Guide

COB Agreement and Attachment

COB AGREEMENT AND ATTACHMENT

The COB Agreement (COBA) is a contract between the Centers for Medicare & Medicaid Services' (CMS) contractor and other health insurers or benefit programs. The COBA specifies all of the essential functions to allow eligible insurers or benefit programs to receive Medicare paid claims automatically after Medicare releases claims from the payment floor.

An electronic copy of this document may be downloaded from the COB Web site. Refer to the Technical Reference section in this guide for more information.

Coordination of Benefits Agreement (COBA)

COBA Claims Selection Glossary

Implementation User Guide

COBA Claims Selection Glossary

COBA CLAIMS SELECTION GLOSSARY

This section defines the 13 claims selection criteria as outlined in Section IV of the COBA Attachment.

INCLUDE/EXCLUDE OPTIONS

1. Type of Bill (TOB)—A 3-digit type of bill used by providers to identify the nature of the health care service received in a facility or institutional health care setting. The 3-digit type of bill is included on claims that are submitted to Part A Medicare claims processing contractors known as intermediaries.

2. Provider State—Claims that may either be included or excluded from the crossover process on the basis of the state in which the provider of service is located. These claims will be identified by the first two positions of the provider identification number, which represent state code. Note that currently this option only applies to claims processed by a Medicare Part A contractor. Part B provider states may be included or excluded by Medicare Contractor Identification Number. DMERC claims may be excluded by specific processing region.

3. Provider Identification Number—Claims that may be either included or excluded from the crossover process on the basis of provider identification number. Note that currently this option only applies to claims processed by a Medicare Part A contractor.

COMMON CLAIM TYPE EXCLUSION OPTIONS

4. Non-assigned claim—A claim on which the physician, practitioner, specialty physician, or supplier did not accept the assignment of a beneficiary's Medicare claim.

5. Original Medicare claims paid at 100%—A claim on which all line items were paid at 100% of the Medicare allowed or approved amount without deductible or co-insurance amounts remaining.

COBA Claims Selection Glossary

6. Original Medicare claims paid at greater than 100% of the submitted charges—A claim, such as a claim for the professional charges incurred at an Ambulatory Surgical Center (ASC) [type of service=F], that is paid at greater than 100% of the charges submitted by the provider of service.

7. 100% Denied Claims, with no additional beneficiary liability—A claim that is completely denied and for which the liability rests with the provider of service rather than the beneficiary.

8. 100% Denied Claims, with additional beneficiary liability—A claim that is completely denied but for which liability rests with the beneficiary.

9. Adjustment claims, monetary—A claim on which the original financial information, such as the amount approved or allowed or the amount paid, was modified.

10. Adjustment claims, non-monetary/statistical—A claim that is modified for the purpose of correcting dates of service and other non-monetary changes but on which the original financial outcome remains unchanged.

11. Medicare Secondary Payer (MSP) claims—Claims that Medicare receives for purposes of making secondary payment.

12. Other Insurance—This option applies when a State Medicaid Agency does not wish to receive claims when a beneficiary has other insurance (Medigap, supplemental policy, TRICARE, or other) that can pay before Medicaid.

13. National Council for Prescription Drug Programs (NCPDP) claims—This option applies when a Trading Partner wishes to exclude NCPDP version 5.1 batch standard 1.1 formatted claims from the crossover process.

Coordination of
Benefits
Agreement
(COBA)

COBA Profile Report

Implementation User Guide

COBA Profile Report

COBA PROFILE REPORT

Upon receipt and successful processing of the COBA and Attachment, the COBC will generate a Profile Report. The Profile Report will also be sent anytime there is an attachment change. The COBA Profile Report displays COBA information as provided by the Trading Partner in the COBA Attachment and lists the Trading Partner's assigned COBA ID (s). The Trading Partner will use the COBA ID in generating test and production eligibility files rather than using any existing insurer identification numbers assigned by Medicare Contractors.

COBA IDs
A Trading Partner may be assigned one or more COBA IDs. At a minimum, the COBC will assign separate COBA IDs to those insurers having Medigap and other lines of business for use in generating Eligibility Files. Trading Partners will also receive separate COBA IDs if:

- The Trading Partner submits separate eligibility files, as in the case of two distinct lines of business;
- The Trading Partner elects separate claims selection options within the same line of business or separate claims selection options per each line of business; or
- There are differences with respect to Sections II, III, and IV of the COBA Attachment.

Trading Partner Profile Report

TP Contact ID:	**Name:**	**Company:**		**TIN:**
COBA ID:	**LOB:**	**Contract Date:**	**Status:**	**Status Date:**

Contact Information:

Administrative
Name:
Title/Position:
Company Name:
Address 1:
Address 2:
City/State/Zip:
Phone/Fax:
Email:
Contact ID:

Technical
Name:
Title/Position:
Company Name:
Address 1:
Address 2:
City/State/Zip:
Phone/Fax:
Email:
Contact ID:

Invoice
Name:
Title/Position:
Company Name:
Address 1:
Address 2:
City/State/Zip:
Phone/Fax:
Email:
Contact ID:

Eligibility File
Frequency:
Type:
Media:

Claims File
Frequency:
Trans Day:
Media:
ISA Qualifier:
ISA Receiver:
NCP Receiver:

Print name on MSN?

Part A Rate Code: **Rate:**
Part B Rate Code: **Rate:**
Contractor(s) Employed

Trading Partner Profile Report

TP Contact ID: **Name:** **Company:** **TIN:**
COBA ID: **LOB:** **Contract Date:** **Status:** **Status Date:**

Part A Inclusion/Exclusion Criteria

Fiscal Intermediary TOBs

_____ **'X' Receive all types of bills**

'X' Exclude Description

_____ **11 Hospital: Inpatient Part A**
_____ **12 Hospital: Inpatient Part B**
_____ **13 Hospital: Outpatient**
_____ **14 Hospital: Other Part B (Non-patient)**
_____ **18 Hospital: Swing Bed**
_____ **21 Skilled Nursing Facility: Inpatient Part**
_____ **22 Skilled Nursing Facility: Inpatient Part**
_____ **23 Skilled Nursing Facility: Outpatient**
_____ **71 Clinic: Rural Health**
_____ **72 Clinic: Freestanding Dialysis**
_____ **74 Clinic: Outpatient Rehabilitation Facility**
_____ **75 Clinic (CORF)**
_____ **76 Clinic: Comprehensive Mental Health**
_____ **83 Special Facility: Hospice Non-Hospital**
_____ **85 Primary Care Hospital**

Specialty Fiscal Intermediary TOBs

_____ **24 SNF: Other Part B (Non-patient)**
_____ **28 SNF: Swing Bed**
_____ **41 Christian Science/Religious Non-Medical (Hospital)**
_____ **73 Clinic: Federally qualified Health**
_____ **79 Clinic: Other**

Fiscal Intermediary/RHHI TOBs

_____ **32 Home Health: Part B Trust Fund**
_____ **33 Home Health: Part A Trust Fund**
_____ **34 Home Health: Outpatient**
_____ **81 Special Facility: Hospice Non-Hospital**
_____ **82 Special Facility: Hospice Hospital**

Part B Inclusion/Exclusion Criteria

_____ **Check here if you wish to receive claims for all provider states.**

'I' Include or 'E' Exclude:

List all provider states to be Included or Excluded as indicated above:

Print in this space the provider number or provider states: _____

_____ **Check here if you wish to receive all DMERC type of claims**

Otherwise: 'X' Exclude the following:

_____ **Region A**
_____ **Region B**
_____ **Region C**
_____ **Region D**

Common Inclusion/Exclusion Criteria

_____ **Check here if you wish to receive all types of claims listed below:**

Otherwise: 'X' Exclude the following:

_____ **Non-Assigned**
_____ **Original Medicare claims paid at 100%**
_____ **Original Medicare claims paid at greater than 100% of submitted charges**
_____ **100% Denied Claims, with NO additional beneficiary liability.**
_____ **100% Denied Claims, with additional beneficiary liability.**
_____ **Adjustment Claims, monetary.**
_____ **Adjustment Claims, non-monetary/statistical.**
_____ **Medicare Secondary Payer (MSP) claims.**
_____ **Claims if no other insurance exists for beneficiary**
_____ **NCPDP**

Trading Partner Profile Report

TP Contact ID:	**Name:**	**Company:**		**TIN:**
COBA ID:	**LOB:**	**Contract Date:**	**Status:**	**Status Date:**

Part A Inclusion/Exclusion Criteria Continued...

_____ **Check here if you wish to receive claims for all providers and all states**

'I' Include or 'E' Exclude:

Provider Identification Number or Provider State:

Print in this space the provider number or provider states:

Coordination of Benefits Agreement (COBA)

COBA TECHNICAL

Implementation User Guide

Coordination of Benefits Agreement (COBA)

Test Procedures

Implementation User Guide

TEST PROCEDURES

Requirements

This section outlines the necessary steps for eligibility and claims file testing with the COBC. The Trading Partner is required to complete all enrollment steps as defined under COBA in the Implementation Checklist section of this guide prior to initiating testing with the COBC. Refer to the Implementation Checklist section within this guide for more information regarding implementation requirements.

- Set up connectivity test. Coordinate testing two-way transmission capability with the COBC, if applicable (i.e., electronic transmissions).

- Obtain a test date from the COBC. Upon receipt of the COBA and Attachments, the COBC will provide you with the next available date to commence testing.

- Provide data transfer information. For tape transfer of COBA information, complete the Tape Transfer Form; otherwise, complete the Electronic Transmission Form contained in this guide. Return the form to the COBC as indicated in the Customer Assistance section of this guide.

- Create test eligibility file(s). Eligibility files must be generated in the required COBA Eligibility File Format using your assigned COBA ID(s) as furnished to you by the COBC. (Note: Parallel tests will normally be done with a full size production eligibility file; however, partial eligibility files may be used.)

- Submit your test eligibility file(s) to the COBC. You may transmit your eligibility file(s) electronically or mail your test eligibility file(s) to the COBC. Refer to the mailing address specified in the Customer Assistance section in this guide. (Note: The eligibility test file will be loaded to the Beneficiary Other Insurance [BOI] file in CWF and testing will occur during the normal course of production.)

Test Procedures

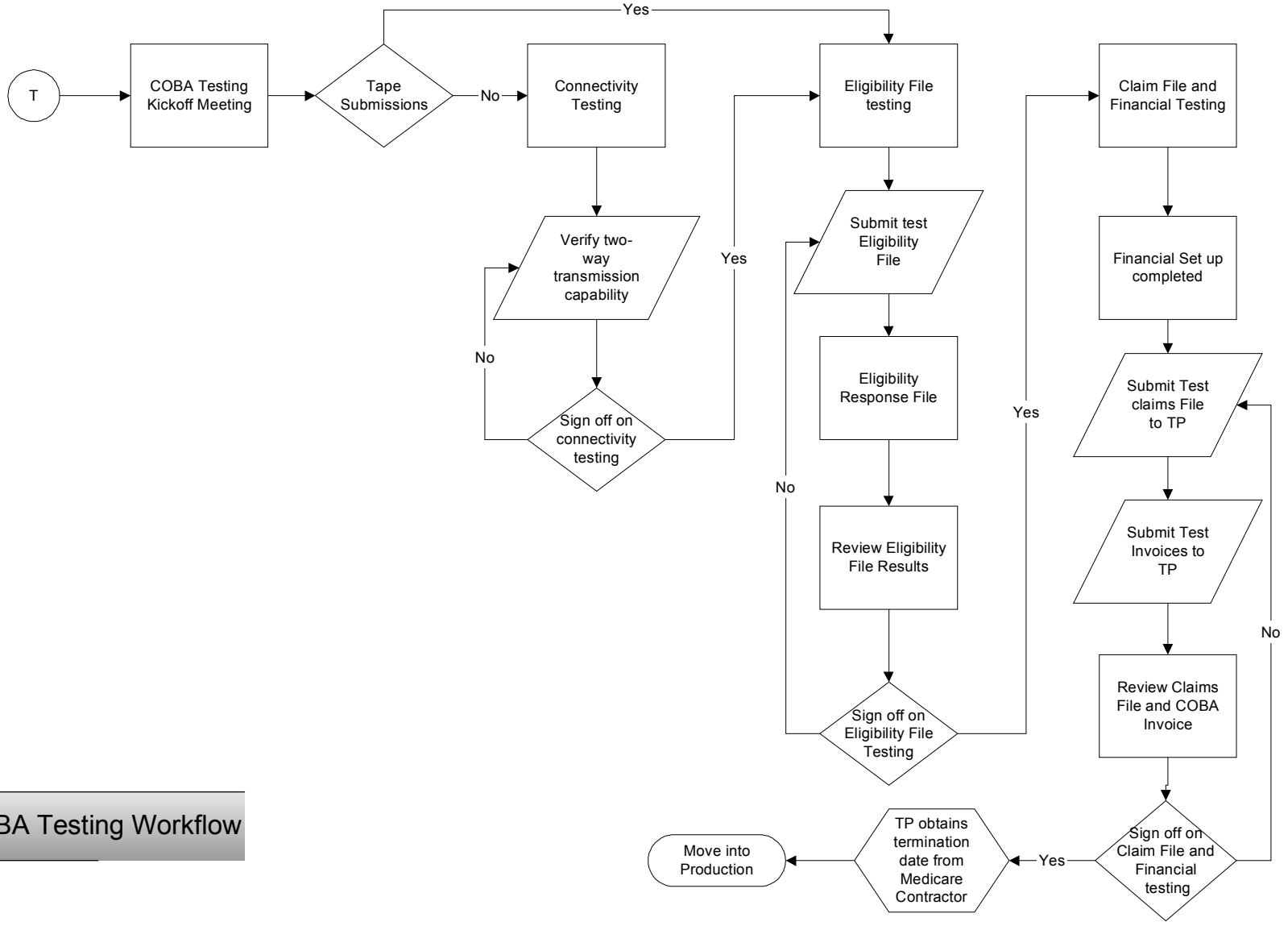
- Review your test eligibility results. The COBC will forward an Eligibility Detail Report that confirms receipt of an eligibility file; summarizes the number of records submitted; lists the number of adds, updates, and deletes; lists all eligibility errors, if any; and explains the reason for each error.
- Review test Claims File(s) from the COBC. The COBC will create and forward Claims Files in the required formats for all claims matching eligibility information and claims selection criteria.
- Sign-off on the test process with the COBC. Once you are satisfied with the test results, call the COBC's EDI department and request a Test Sign off Form. Follow the instructions as outlined on this form.
- Perform Financial Testing.

Test Procedures

TEST PROCEDURES

Flowchart

The following page displays the flowchart for the COBA test process.



COBA Testing Workflow

Coordination of Benefits Agreement (COBA)

Tape Transfer

Implementation User Guide

Tape Transfer

TAPE TRANSFER

Specifications

The following information is applicable to those Trading Partners that will be using tape-to-tape transfer for COBA information.

1. Tape cartridges must be a 9-track.
2. The sender must use IBM standard label.
3. Block size must be maximum.
4. If cartridges are used, they must be 3480 or 3490.
5. 6250 BPI is preferred for reel tapes. However, 1600 BPI is also accepted.

Tape Transfer

Transfer Form

Trading Partners that elect to send/receive files on tape must complete and return this form to the COBC. If using multiple claims file locations, Trading Partners shall copy and complete separate Tape Transfer Forms.

Forward all Eligibility Files to the address below

Medicare-Coordination of Benefits
Attn: COBA Program/EDI Department
PO Box 660
New York, NY 10274-0660

or

Medicare-Coordination of Benefits
Attn: COBA Program/EDI Department
25 Broadway (12th Floor)
New York, NY 10004
(NOTE: Please be sure to use the full address when sending files information overnight to the COBC)

The COBC will forward all Claims Files to the address below

Trading Partner Name: _____

Attention: _____

COBA ID (s): _____

Address1: _____

Address2: _____

City/State/Zip: _____

Tape Transfer

Transmittal Letter

Trading Partners that elect to submit eligibility files on tape must accompany each tape with a transmittal letter. If your organization does not have a standard form, please use this form.

Trading Partner Name: _____

Attention: _____

COBA ID (s): _____

Address: _____

Volume/Serial #: _____

Data Set Name: _____

Record Count: _____

Media Type: _____ 3480 Cartridge _____6250 BPI
_____ 3490 Cartridge _____1600 BPI

Date Mailed: _____

Coordination of Benefits Agreement (COBA)

Electronic Transmission

Implementation User Guide

Electronic Transmission

ELECTRONIC TRANSMISSION

Specifications

The following information is applicable to those Trading Partners that will be using electronic transmission for COBA information. The Trading Partner will specify the method of transmission in the COBA. CMS' preferred method of electronic transmission is NDM via the AT&T Global Network System, Connect: Direct using TCP/IP. The AT&T Global Network Service, better known as AGNS or Advantis, is like a private internet. Only subscribers to that network can participate in sessions with other subscribers' entities. The network uses an encryption scheme of triple DES as a default to keep the physical transport of the data source.

Other methods of data transmission will be considered as long as they meet CMS' standard security data requirements. However, TCP/IP or SNA will be made available to the trading partner. CMS is also looking to implement a dial-up option for those trading partners that anticipate having low crossover volumes. The following provides an overview of how COBC plans to accomplish routing users to either the FTP or NDM applications via the AGNS network:

When a trading partner customer comes in to COBC via the ATT Global Network, that partner will be using a registered Internet address that belongs to ATT to ensure customer routing via the AGNS network.

The ATT Global account ID for COBA will be BXGH that has a frame-relay connection via an AGNS managed router to the ATT Cloud. The ATT managed router at the COBC's 441 9th Ave site is called "BXGHNEWY." CMS has put in a connection from its site for NDM/IP to the 441 location.

A customer will need a PVC for a private line to the ATT network or a modem dial line to the ATT network using appropriate ATT software.

Electronic Transmission

If the customer will use a dial line, the ATT software will assign to the user from a pool of 32 block addresses a specific 32.xxx.yyy.zzz address to use as its Source IP address.

The user will need to have an ATT account, Userid and Password to connect.

The destination IP that the user will specify for GHI will depend on whether the user is using NDM/IP or FTP. It will probably be a 32.xxx.yyy.zzz address that will be passed from the COBC's AGNS router to the COBC's firewall.

The COBC has a 32.xxx.yyy.zzz setup in its AGNS router currently for CMS use of NDM/IP and probably can expand this for other users of this product.

The COBC has a firewall that translates the user destination address (32.xxx.yyy.zzz) to a GHI network address that will route to the desired host and application.

The COBC has also had to provide static routing in its core router to send the data back to the AGNS network so the user Source IP is also important. This will also apply to COBC's Firewall configuration. (Source IP addressing for dial will be assigned by the ATT software via DHCP)

For private line users connected to the AGNS network, they will have a site Source IP either directly out of AGNS or defined as a translated address in their Firewall (if any).

Firewall and router modifications may be set up an individual basis.

Electronic Transmission

Connect Direct Form

If you will be using the AT & T Global Network Service (AGNS) to send and receive information via transmission, please provide us with the following network information:

_____ Check here if the following represents transmission information for both Eligibility Files submission and Claims Files receipt.

Otherwise, copy and complete separate Connect Direct Forms and indicate, below, the following file representation:

_____ Eligibility File Submission or
_____ Claims File Receipt

Trading Partner's Information

Trading Partner Name: _____

COBA IDs: _____

Account ID: _____

Node ID: _____

Net ID: _____

Appl ID: _____

Trading Partners or Trading Partner contractors must provide the following Data Set Names (DSNs) to the COBC for receipt of the Eligibility Detail Report and Claims Files (unless excluded in Section IV of the COBA Attachment):

Eligibility Detail Report:

Eligibility Detail Report Test: _____

Eligibility Detail Report Production: _____
(Note: If submitting multiple Eligibility Files, please provide multiple DSNs.)

Electronic Transmission

ANSI 837 Version 4010A1 (Institutional):

Claims File Test: _____

Claims File Production: _____

ANSI 837 Version 4010A1 (Professional):

Claims File Test: _____

Claims File Production: _____

NCPDP version 5.1 batch standard 1.1 format:

Claims File Test: _____

Claims File Production: _____

Coordination of Benefits Contractor's Information

Account ID: BXGH

Node ID: GHINY

Net ID: NETGHI

Appl ID: A08NDM

Trading Partners or Trading Partner contractors will need to use the following Data Set Names (DSN) for submitting eligibility files for COBA processing via Connect Direct:

Test
TCOB.BA.NDM.COBA.CBXXXXX.ELIG(+1)

Where XXXXX = the last five digits of the Trading Partner's COBA ID.

Electronic Transmission

Production
Production files will be prefixed with “PCOB” instead of “TCOB.”

Questions or Special Instructions:
If you have any technical questions or need assistance with establishing this transmission link (e.g., NDM specific connection information), please contact our EDI Help Desk at (646) 458-6740.

Coordination of Benefits Agreement (COBA)

Eligibility File

Implementation User Guide

Eligibility File

ELIGIBILITY FILE

Process

The Trading Partner or the Trading Partner's contractor will transfer eligibility files to the COBC based on the terms defined within its COBA for all Medicare beneficiaries for whom it provides supplemental insurance coverage.

Frequency

The Trading Partner may provide eligibility files on a bi-weekly or monthly basis. The Trading Partner will need to indicate its frequency of Eligibility File submission to the COBC in the COBA Attachment. The eligibility file frequency may be modified or changed by the Trading Partner. To communicate any changes to its selected options, the Trading Partner may complete and submit another COBA Attachment, indicating on page 1 that this is a change.

There is no cut-off time for eligibility file submission. If the Trading Partner does not submit files, the eligibility remains unaltered on CWF.

If the Trading Partner receives an error file, the Trading Partner should correct the file immediately, off-schedule, and resend to COBC.

The COBC will load Eligibility Files on a daily basis. The Eligibility File data are uploaded to CWF within five business days of receipt.

Process Cont:

Validation of the Eligibility file

Data validation routines will be applied to all eligibility files. The COBC will provide a detail-level report back to the Trading Partner identifying eligibility records received, accepted, and denied. If the file has a fatal error, it is the Trading Partner's responsibility to resend the corrected file. The entire file will fail if:

- No header or trailer records are present.
- The COBA ID is invalid.
- The trailer record count does not match the actual record count.
- The file contains less than 70% of the records currently in our database. For Trading Partners that elect full file replacement this condition will result in a delayed processing of the Trading Partners eligibility file. (Note: Each COBA ID will be edited and checked for the required 70% threshold. The COBC's EDI representative will notify the Trading Partner of COBA IDs that fail the threshold. The EDI representative will have the capability to override the system and continue process for approved COBA IDs that do not meet the required 70% threshold.)

If an entire Eligibility File rejects, the COBA process will generate a detailed report. The COBA process will continue to crossover claims based on the prior Eligibility File. For those eligibility files that do not contain a fatal error, the COBC will attempt to process each eligibility record on the file.

Eligibility Update Process

There is no limit to the number of COBA IDs that can be contained in one eligibility file; however, multiple eligibility files per COBA ID are not acceptable. Trading Partners with multiple COBA IDs have the option of submitting a separate Eligibility File for each COBA ID or combining all their Eligibility records into a single file. In the combined file scenario, all beneficiary records must be sorted by COBA IDs and separated by a header and trailer. Trading Partners will complete an Electronic Transmission Form on which they designate their transmission method.

Eligibility File

Process Cont:

Eligibility File Type

The COBA process allows for two separate eligibility file update methodologies: Adds, Changes, and Deletes and Full File Replacement. (Note: Full File replacement will be eliminated in the future.) The Trading Partner will need to indicate its eligibility file type to the COBC in the COBA Attachment. The COBC differentiates full file replacements from updates with the use of the file update indicator field. When a Trading Partner elects full-file replacement, the indicator is not reflected on the eligibility file.

Adds, Changes, and Deletes

The CWF system is ideally suited for processing adds, changes, and deletes. Thus, the preferred eligibility update methodology for the COBA process is adds, changes, and deletes. In this method, only eligibility records to be added to, changed, or deleted from the existing eligibility file are submitted to the COBA process. Records that remain unchanged do not have to be included.

The following defines adds, changes, and deletes and provides an example of each:

Adds: New information the Trading Partner provides the COBA process on a covered individual for whom the Trading Partner provides supplemental coverage. This information was never provided to the COBA process previously.

Example: John Smith is a newly covered individual under one of the Trading Partner's plans. The Trading Partner wants to receive Medicare paid claims information for John Smith. Insurance plan X provides individual information for the first time to the COBC to identify John Smith as a covered individual.

Eligibility File

Process Cont:

Changes: Updates to covered individual records that were previously provided to the COBA process.

Example: Jane Doe was previously posted to the COBA eligibility database as a covered individual by insurer Y via an Add. Three months later, Jane Doe ceased coverage with that insurer. Insurer Y sends this change to the COBA process in the next "update" eligibility file.

Deletes: Removal of a record that was previously posted to the COBA eligibility database in error.

Example: John Doe was previously added to the COBA eligibility database as a covered individual by insurer Z. However, insurer Z determined that it had erroneously identified John Doe as a covered individual through its employer retiree plan. In reality, John Doe was actively employed.

Full File Replacement

Although full file replacement is not a preferred methodology for updating eligibility files, it will be supported under the COBA process for the near term. In this method, the contents of the existing COBA eligibility database will be completely replaced by the contents of the new submitted file. CWF actually treats a full file replacement as add, change, and delete commands. The COBA process compares existing eligibility information against incoming eligibility information and converts the incoming data into add, change, or delete actions. Any record on the existing file that does not match an incoming record will be deleted.

Eligibility File

Process Cont:

Example: Insurance plan Y provides the COBA process with an eligibility file using the full file replacement methodology. This file is processed and contains six unreadable records, which are rejected by the COBA process. Any individual whose eligibility was contained in the rejected records will no longer be represented in the database. It is the responsibility of the Trading Partner to correct the error records and resend the eligibility records. These corrections may be done outside of the normal frequency for the eligibility file submission as specified in the COBA Attachment Section III.A.

For full file replacement, incoming records are matched to existing records using the HICN and three of the four following criteria: First Name (1st initial), Surname (1st six characters), Date of Birth, and Sex Code. If the HICN plus at least three of these criteria do not match, the original record is deleted rather than changed. Trading Partners must be especially careful to ensure that these matching criteria are correctly reported.

Detailed Eligibility Report

When all records in the eligibility file have been processed, the COBC will generate a detailed eligibility report to the Trading Partner. The Eligibility File Detail Report will be transmitted via the same transmission method by which it was received. Each eligibility reply report will specify the COBA ID and the File ID that uniquely identifies the report. Total counts will be given for number of eligibility records submitted; number of add, update, and delete records accepted; and total number of "BO" errors. (See COBA Eligibility Detail Report in this section.)

Trading Partners with multiple COBA IDs can expect to receive an error report for each COBA ID submitted.

Valid Record Match

The primary match for records will be on the HICN. A secondary match will be on the first initial of the beneficiary's First Name, Date of Birth, Sex Code, and the first six characters of the beneficiary surname. In addition to the primary matching element, eligibility records that match on three out of the four matching criteria in the secondary match will pass.

Eligibility File

Process Cont:

Errors
Each record that receives one or more errors will also be included in the detail section of the report. The detail section will specify HICN, Beneficiary Surname, Date of Birth, Sex Code, Effective Date, Supplemental ID, BO Error (up to 4 errors), and BO Description. Records with the following errors will not be processed (i.e. not loaded):

- BO01 – Invalid or missing HICN
- BO02 – Invalid or missing beneficiary surname
- BO03 – Invalid or missing beneficiary date of birth
- BO04 – Invalid or missing beneficiary sex code (NOTE: If the beneficiary sex code is unknown default to M)
- BO14 – Invalid insurance effective date
- BO15 – Invalid insurance termination date

Note: BO01 through BO04 errors could occur once, while BO14 and BO15, the effective and termination errors, could occur for each of the five dates on the eligibility file.

Corrections
The Trading Partner is responsible for correcting errored records immediately and resending the eligibility records to the COBC. Corrections will be allowed as off-schedule transmissions. For those who use full file replacement, the corrected file must be a full file replacement. For those who use adds, updates and deletes, submit only the corrected records. Since multiple BO errors may be encountered, CWF will accommodate up to four BOI error replies per eligibility record.

Turn-around Time
The COBC will process eligibility files, including corrected files, within five business days of receipt. Eligibility File corrections to the CWF system will occur within five business days of receipt of the Eligibility File. The BO Error Report based on the corrected file will be available on the sixth day.

Eligibility File

Process Cont:

Data Set Names

Connect Direct users refer to the Electronic Transmission section. Tape users must properly label tapes and forward a Tape Transmittal Letter indicating the appropriate data set name.

Creating a single eligibility file for use of multiple COBA IDs

The COBC will allow Trading Partners or Trading Partners' contractors that have been assigned multiple IDs the option to combine all of their eligibility records with multiple COBA IDs into a single file. The COBA process requires that all beneficiary records **must** be separated by a new header and trailer within the file. The Header record includes the record type, COBA ID, creation date, and beneficiary state code. (Note: this code is optional and is not used by the COBA process.) Trading Partners should sort the Eligibility File by COBA ID. Here is an example for a Trading Partner or Trading Partner contractor with multiple COBA IDs:

Header record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Trailer record
Header record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Trailer record

Eligibility File

Process Cont:

Eligibility File Process: Drug Coverage (Medicare Part D)

Background
Title 1 of the Medicare Modernization Act (MMA) of 2003 establishes a new voluntary outpatient prescription drug benefit under Part D of Title XVIII of the Social Security Act that takes effect on January 1, 2006. This new drug benefit, along with an employer subsidy for qualified retiree health plans, is referred to as ***Medicare Part D***.

Purpose
The other drug coverage information supplied by the Trading Partners will enable CMS to pass along information so that pharmacies can electronically coordinate benefits in real time with other payers that provide drug coverage for Medicare beneficiaries.

Drug Coverage and the COBA Program
Because the COBA program is designed to coordinate benefits with supplemental payers/insurers, prescription drug benefit information will need to be incorporated into the eligibility files exchanged between Trading Partners and the COBC. For this purpose, CMS will enable Trading Partners to submit drug coverage eligibility information through one of two channels: (1) a new eligibility record, known as the ***E02 record***, which will be integrated into the COBA program or (2) the existing Voluntary Data Sharing Agreement (VDSA) program.

Regardless of the channel selected by a given Trading Partner, CMS will handle the information as follows:

- CMS will collect and compare supplemental payers' drug coverage information submitted by the Trading Partner with a beneficiary's enrollment in Medicare Part D.
- Where a match occurs, CMS will pass the other drug coverage information to the Part D plans and notify the supplemental payers about the beneficiary's entitlement to Medicare Part D benefits via a response file.
- Where no match occurs, CMS will drop the information from its files.

Eligibility File

Medigap plans will receive Part D eligibility response files containing Part D Medicare entitlement information to prevent Medigap plans from providing drug coverage to beneficiaries who have enrolled in Part D. This response file record layout may be found after the COBA Eligibility detail report.

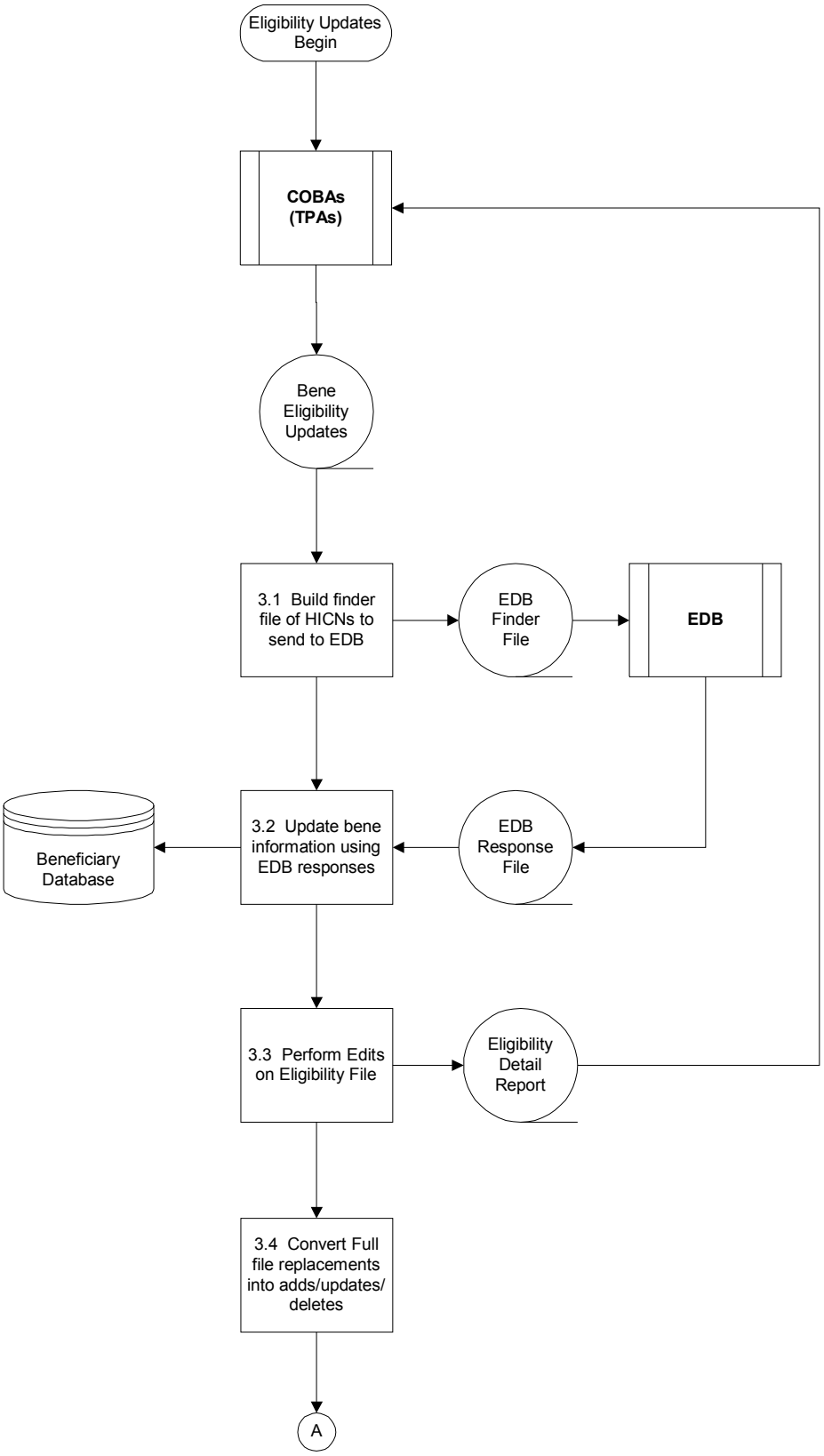
CMS prefers that Trading Partners submit drug coverage information for their ***inactive*** (retired) covered beneficiaries through the COBA process and that Trading Partners submit drug coverage information for their ***active*** (not retired) covered beneficiaries through the VDSA program. The COBA process cannot be used to submit drug coverage for the insurers active covered beneficiaries. Trading partners that choose to submit drug coverage information via the COBA process should begin planning now to modify their existing processes prior to October 2005 to allow adequate time for testing.

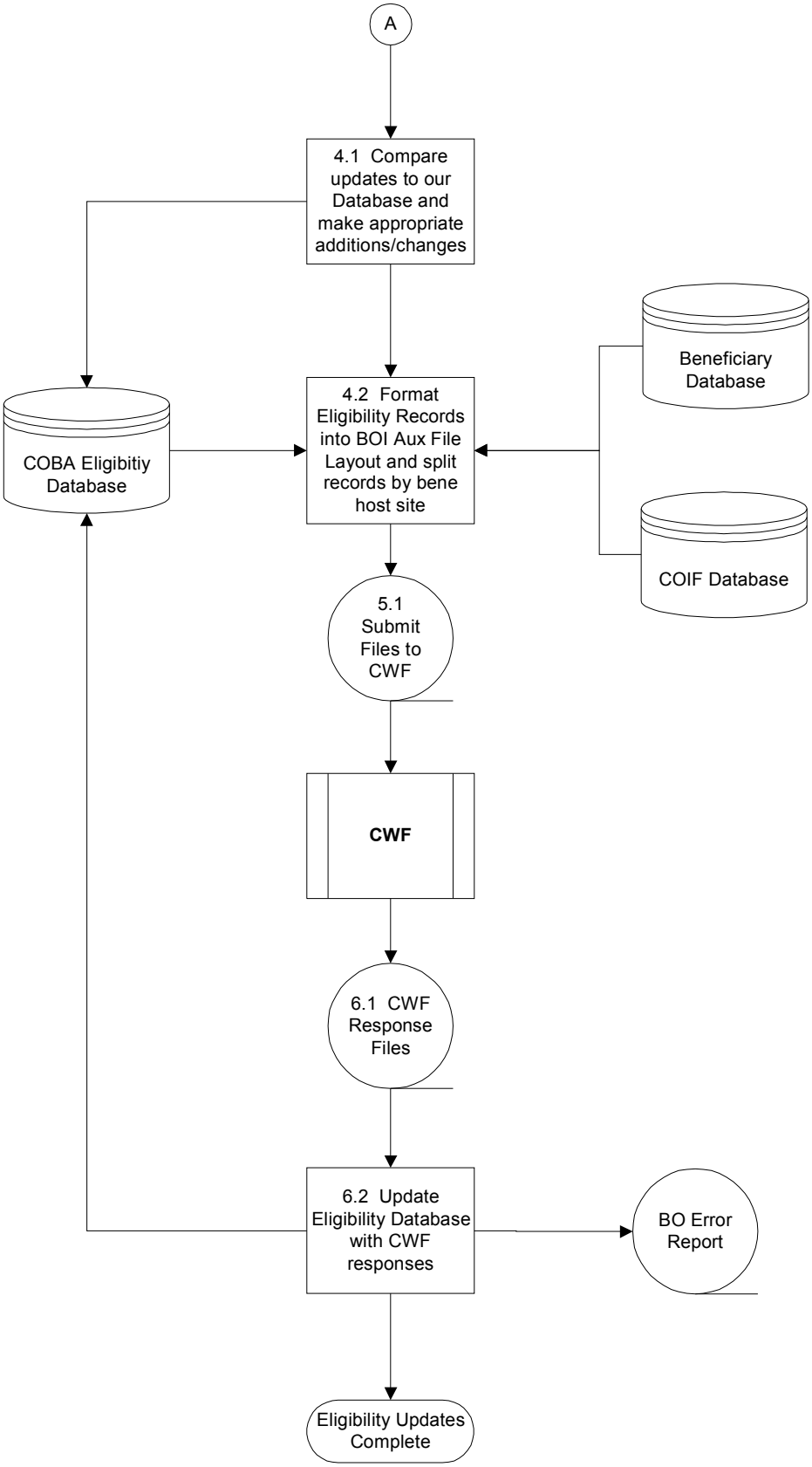
The E02 record will also allow Trading Partners the flexibility of submitting the SSN in place of the Medicare HICN, which should ease the transition. Another advantage is that Trading Partners will be able to submit E02 records more frequently—biweekly and monthly—whereas, the VDSA restricts submissions to a quarterly basis. A flowchart of the COBA Drug and Part D processing may be found in Attachment F.

Eligibility File

Flowchart

The following flowchart displays how the COBC's COBA Eligibility File Process will edit, validate, and process Trading Partner's eligibility files.


Eligibility Updates Begin
COBAs (TPAs)
Bene Eligibility Updates
3.1 Build finder file of HICNs to send to EDB
EDB Finder File
EDB
Beneficiary Database
3.2 Update bene information using EDB responses
EDB Response File
3.3 Perform Edits on Eligibility File
Eligibility Detail Report
3.4 Convert Full file replacements into adds/updates/ deletes
A


A
4.1 Compare updates to our Database and make appropriate additions/changes
Beneficiary Database
COBA Eligibitiy Database
4.2 Format Eligibility Records into BOI Aux File Layout and split records by bene host site
COIF Database
5.1 Submit Files to CWF
CWF
6.1 CWF Response Files
6.2 Update Eligibility Database with CWF responses
BO Error Report
Eligibility Updates Complete

Eligibility File

Format

COBA uses a 200-byte standard COB Eligibility file format. CMS does not have any plans to change this format. The following file layout provides the required COBA Eligibility File Format that will be used by Trading Partners to identify their eligible beneficiaries to receive Medicare paid claims information for their supplemental payment processing. All Trading Partners must use the following format. No other Eligibility File Format will be accepted for COBA processing.

Notification Timeframes for Non-Receipt, Indecipherable, and/or Damaged Claim Files

Electronic transmissions

If the Eligibility File is not readable, the receiving party agrees to notify the sender within seven (7) business days from receipt of the file by telephone. The sender shall send a replacement Eligibility File to the receiving party. Until receipt of the replacement Eligibility File, the CMS Contractor will transfer claims based on the last transmitted Eligibility File that was readable and was posted to CMS' Common Working File.

If the sender does not receive a COBA Eligibility File Detail Report within seven (7) business days from the transmission date, the sender shall contact the CMS Contractor by telephone as listed in Section II.B of the Attachment.

Non-electronic Eligibility Files

If the Eligibility File is damaged or not readable, the receiving party agrees to notify the sender within seven (7) business days from receipt of the file by telephone. The sender shall send a replacement Eligibility File to the receiving party upon notification of the damaged or indecipherable file. Until receipt of the replacement Eligibility File, the CMS Contractor will transfer claims based on the last transferred Eligibility File that was not damaged or readable and was posted to CMS' Common Working File.

If the sender does not receive a COBA Eligibility File Detail Report within ten (10) business days from the estimated delivery date, the sender shall contact the CMS Contractor by telephone as listed in Section II.B of the Attachment.

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
HEADER RECORD TYPE	**Value - E00**	3X	O	E00.001
HEADER COBA ID	COBA ID assigned by the COBC	9X	O	E00.002
HEADER CREATION DATE	Date the record was created; format: (CCYYMMDD)	8X	O	E00.003
HEADER BENEFICIARY STATE CODE	Beneficiary State of residence **NOTE: This field will not be used by the COBA Process**	2X	O	E00.004
FILLER	Blank Field. Value is spaces.	178X	O	E00.005

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
RECORD TYPE	**Value - E01**	3X	M	E01.001
COBA ID	Coordination of Benefits Agreement Identification Number	9X	M	E01.002
FILE EFFECTIVE DATE	Effective date of file; format: (CCYYMMDD)	8X	M	E01.003
FILE UPDATE INDICATOR	Type of update values: A-Add, C-Change, D-Delete **NOTE: This field will not be used by the COBA Process for Full File Replacement.**	1X	O	E01.004
*BENEFICIARY SURNAME	Beneficiary last name	20X	M	E01.005
*BENEFICIARY FIRST	Beneficiary first name	12X	M	E01.006
BENEFICIARY MIDDLE INITIAL	Beneficiary middle initial	1X	O	E01.007
*BENEFICIARY BIRTH DATE	Beneficiary date of birth; format: (CCYYMMDD)	8X	M	E01.008
*BENEFICIARY SEX CODE	Beneficiary sex code values: M = Male F = Female **NOTE: If unknown default to M**	1X	M	E01.009
BENEFICIARY HIC NUMBER	Beneficiary Medicare Health Insurance Claim Number	12X	M	E01.010

*Note: In addition to the HICN (primary matching element), the matching criteria will be on (1) Beneficiary Surname (first six characters), (2) Beneficiary First Name (first character), (3) Beneficiary Birth Date, and (4) Beneficiary Sex Code. Trading Partners should use the value code representation of "M" as a default for the Beneficiary's Sex Code, if sex is unknown. Beneficiary records matching on the HICN and three out of the four matching criteria will pass.

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
BENEFICIARY SUPPLEMENTAL ID NUMBER	Supplemental ID on file with sender. Should be the same as what is submitted on the claim.	25X	O	E01.011
BENEFICIARY GROUP POLICY NUMBER	Supplemental policy number on file. Should be the same as what is submitted on the claim.	20X	O	E01.012
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-1	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	M	E01.013
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-1	Medicare supplemental "to" date; (Note: this is the coverage through date) format: (CCYYMMDD) **NOTE: Indicate zeros for open-ended dates.**	8N	M	E01.014
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-2	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	O	E01.015
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-2	Medicare supplemental "to" date; format: (CCYYMMDD) **NOTE: Indicate zeros for open-ended dates.**	8N	O	E01.016
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-3	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	O	E01.017
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-3	Medicare supplemental "to" date; format: (CCYYMMDD) **NOTE: Indicate zeros for open-ended dates.**	8N	O	E01.018

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-4	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	O	E01.019
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-4	Medicare supplemental "to" date; format: (CCYYMMDD) **NOTE: Indicate zeros for open-ended dates.**	8N	O	E01.020
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-5	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	O	E01.021
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-5	Medicare supplemental "to" date; format: (CCYYMMDD) **NOTE: Indicate zeros for open-ended dates.**	8N	O	E01.022

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
RECORD TYPE	**Value is 'E02'.**	3X	M	E02.001
COBA ID	The Trading Partner's COBA ID. All 5-byte IDs should be prefixed with 5 zeros.	10X	M	E02.002
SURNAME	Beneficiary's Surname.	20X	M	E02.003
FIRST NAME	Beneficiary's First Name.	12X	M	E02.004
MIDDLE INITIAL	Beneficiary's Middle Initial	1X	O	E02.005
DATE OF BIRTH	Beneficiary's Date of Birth. Formatted as CCYYMMDD.	8X	M	E02.006
BENEFICIARY SEX CODE	Valid values are: 0 - Unknown 1 - Male 2 – Female	1X	M	E02.007
SSN	Beneficiary's Social Security Number. **(Not needed if HICN is reported.)**	9X		E02.008
HICN	Beneficiary's Medicare Health Identification Number. **(Not needed if SSN is reported)**	12X		E02.009
COVERAGE START DATE	Beneficiary's Start Date for Drug Coverage.	8N	M	E02.010
COVERAGE END DATE	Beneficiary's Termination Date for Drug Coverage. **(Required if exist)**	8N		E02.011
TRANSACTION TYPE	A – Add U – Update D – Delete Q – Query Only * **(Not required if Full File Replacement)**	1X		E02.012
DOCUMENT CONTROL NUMBER	Trading Partner Document Control number	15X	O	E02.013
NPLAN ID	Future Requirement	10X	O	E02.014

X = ALPHA NUMERIC = LEFT JUSTIFY SPACE FILL
N = NUMERIC = RIGHT JUSTIFY ZERO FILL

M = MANDATORY
O = OPTIONAL

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
INSURANCE TYPE CODE	Type of Insurance. Valid values are: C - TriCare H - Health Reimbursement Account (non pharmacy network benefit) G – Medigap M – Major Medical Account (non pharmacy network benefit) O - Other S – SPAP U - Medicaid W – Supplemental	1X	M	E02.015
PERSON CODE	Patient's relationship to the insured.	3X	M	E02.016
RX ID/ POLICY NUMBER	Identification Number of the Insured **(MANDATORY if pharmacy network benefit coverage) (If plan is a non pharmacy network benefit, use individual policy number)**	20X		E02.017
RX GROUP NUMBER	Pharmacy Group Number	15X		E02.018
RX BIN NUMBER	Pharmacy BIN Number **(MANDATORY if pharmacy network benefit coverage)**	6X		E02.019
RX PROCESSOR CONTROL NUMBER (PCN)	Pharmacy Processor Control Number	10X		E02.020
TOLL FREE NUMBER	Phone number to call in case there are issues with Rx claims processing. This is an optional field.	18X		E02.021
FILLER	Reserved for future use. Value should be spaces.	9X		E02.022

Underlined data fields will be used for add, update and delete matching criteria.

*Query only mandatory fields are: Record Type, COBA ID, Surname, First Name, Date of Birth, Beneficiary Sex Code, (HICN or Coverage Start Date)

We are required to match on 3 of the 4 elements for personal identifiers: Surname, First Name, Date of Birth, and Beneficiary Sex Code.

X = ALPHA NUMERIC = LEFT JUSTIFY SPACE FILL
N = NUMERIC = RIGHT JUSTIFY ZERO FILL

M = MANDATORY
O = OPTIONAL

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
TRAILER RECORD TYPE	**Value - E99**	3X	M	E99.001
TRAILER RECORD COUNT	Total number of records in the file **excluding E00 and E99**.	7N	M	E99.002
FILLER	Blank Field. Value is spaces.	190X	M	E99.003

Eligibility File

DETAIL REPORT

The following displays the COBA Eligibility Detail Report. Refer to the Eligibility File Process as described above for more information regarding the generation and purpose of this report.

PROGRAM: XXXXX99 COB REPORT CYCLE DATE: MM/DD/YY
REPORT#: D046 COBA ELIGIBILITY DETAIL REPORT RUN DATE: MM/DD/YY
PAGE: 999

COBA ID: XXXXXXXXXX FILE ID: XXXXXXXXXXXX

HICN	SURNAME	DATE OF BIRTH	SEX CODE	EFF. DATE	SUPPLEMENTAL ID	BO ERROR
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX

TOTAL NUMBER OF RECORDS SUBMITTED : 999,999,999
NUMBER OF ADD RECORDS ACCEPTED : 999,999,999
NUMBER OF UPDATE RECORDS ACCEPTED : 999,999,999
NUMBER OF DELETE RECORDS ACCEPTED : 999,999,999
TOTAL NUMBER OF BO ERRORS : 999,999,999

Drug Coverage Eligibility Response Record Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
1.	COBA ID	10X	1-10	The Trading Partner's COBA ID. All 5-byte IDs should be prefixed with 5 zeros.
2.	Surname	20X	11-30	Beneficiary's Surname
3.	First Name	12X	31-42	Beneficiary's First Name
4.	Middle Initial	1X	43-43	Beneficiary's Middle Initial
5.	Date of Birth	8X	44-51	Beneficiary's Date of Birth. Formatted as CCYYMMDD.
6.	Sex Code	1X	52-52	Valid values are: 0 - Unknown 1 - Male 2 - Female
7.	SSN	9X	53-61	Beneficiary's Social Security Number. Not needed if HICN is reported.
8.	HICN	12X	62-73	Beneficiary's Medicare Health Identification Number.
9.	Coverage Start Date	8N	74-81	Beneficiary's Start Date for Drug Coverage.
10.	Coverage End Date	8N	82-89	Beneficiary's Termination Date for Drug Coverage.
11.	Plan Document Control Number	15N	90-104	DCN assign by the Trading Partner
12.	Transaction Type	1X	105-105	A - Add U – Update D – Delete Q – Query Only
13.	NPlan ID	10	106-115	Future Use
14.	Insurance Type Code	1X	116-116	Type of Insurance. Valid values are: C - TriCare H - Health Reimbursement Account G - Medigap M – Major Medical O – Other S – SPAP U - Medicaid W - Supplemental

Drug Coverage Eligibility Response Record Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
15.	COBC Document Control Number	15N	117-131	DCN assigned by the COBC
16.	Enrollment Relationship Code	2X	132-133	Patient's relationship to the insured.
17.	Disposition Date	8N	134-141	Date of current Disposition
18.	Disposition	2X	142-143	A code signifying the acceptance or rejection of the record. Valid values are: 01 - Record accepted 02 – Record accepted with warnings 51 – Record rejected (no match on SSN or HICN) 55 – Record reject (no match on personnal characteristic) SP – Record reject (See Error code(s))
19.	Edit Code 1	4X	144-147	
20.	Edit Code 2	4X	148-151	
21.	Edit Code 3	4X	149-152	
22.	Edit Code 4	4X	153-156	
23.	Date of Death	8N	157-164	Date of Death
24.	Current Medicare Part A Effective Date	8N	165-172	Effective Date of Medicare Part A Coverage. Formatted as CCYYMMDD.
25.	Current Medicare Part A Termination Date	8N	173-180	Termination Date of Medicare Part A Coverage. Formatted as CCYYMMDD. * Zeros if ongoing
26.	Current Medicare Part B Effective Date	8N	181-188	Effective Date of Medicare Part B Coverage. Formatted as CCYYMMDD.
27.	Current Medicare Part B Termination Date	8N	189-196	Termination Date of Medicare Part B Coverage. Formatted as CCYYMMDD. * Zeros if ongoing
28.	Current Medicare MAPD/PDP Contractor Number	9X	197-205	Medicare Advantage Prescription Drug Plan (Letter H plus 4 digits)

Drug Coverage Eligibility Response Record Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
29.	Current Medicare MAPD/PDP Effective Date	8N	206-213	Effective Date of Medicare HMO Coverage. Formatted as CCYYMMDD.
30.	Current Medicare MAPD/PDP Termination Date	8N	214-221	Termination Date of Medicare HMO Coverage. Formatted as CCYYMMDD. * Zeros if ongoing
31.	Current Medicare Part D Effective Date /PDP Contractor Number	9x	222-229	Effective Date of Medicare Part D Coverage. Formatted as CCYYMMDD.
32.	Current Medicare Part D Termination Date	8N	231-238	Termination Date of Medicare Part D Coverage. Formatted as CCYYMMDD. * Zeros if ongoing.
33.	Filler	8N	239-400	Spaces

The errors and disposition codes for the records with Drug coverage that would apply are as follows:

SP 12 Invalid HIC Number. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.

SP 13 Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.

SP 14 Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blanks, contain spaces, numeric characters or punctuation marks.

SP 15 Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blanks, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.

SP 16 Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following:

1 = Male
2 = Female

SP 19 Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters must include the following:

0 = Add Record
1 = Delete Record
2 = Update Record

SP 31 Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.

SP 47 No valid record exists for delete request. Attempt to delete a nonexistent MSP will cause a reject.

SP 62 Incoming termination date is less that effective date. MSP termination date must be greater than the effective date.

Additionally COBC will provide RX specific errors:

DX 01	Missing RX ID
DX 02	Missing RX BIN
DX 03	Missing RX Group Number
DX 04	Missing Group Policy Number
DX 05	Missing Individual Policy Number

Coordination of Benefits Agreement (COBA)

Claims File

Implementation User Guide

Claims File

CLAIMS FILE

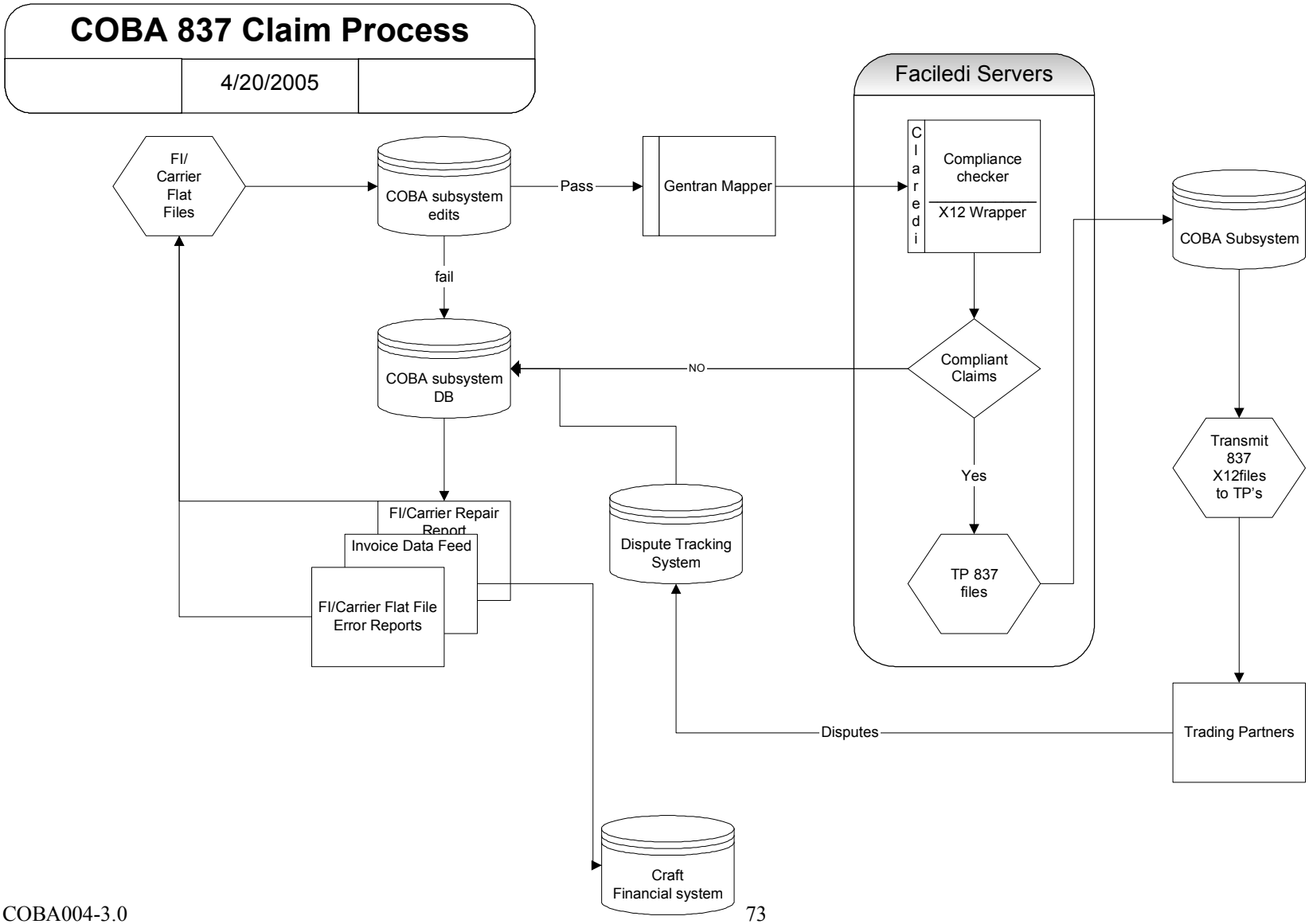
Process

Medicare Contractors will submit all claims for crossover to the COBC nightly via 837 flat file formats and/or NCPDP. The COBC will edit claims for required elements. Any files that fail business edits will not be processed. Instead, the COBC will ask the Intermediaries or Carriers to re-transmit the entire file. Upon acceptance of the file, the COBC will then cross the claim to the appropriate Trading Partner using the COBA ID provided by the Medicare Contractors (from CWF), after referencing the frequency and media type specifications established in the COBA database for the Trading Partner. A COBA trading partner will receive up to three claims files (Institutional, Professional, and NCPDP) per COBA ID (1 per format) or three per all COBA IDs, based upon the exclusion criteria selected in the COB Agreement. All electronic claims, with the exception of NCPDP transfer claims, must be received in ANSI 837 Version 4010A1 (Institutional/Professional). NCPDP will be sent in the NCPDP version 5.1 batch standard 1.1 format. (Note: Data validation routines will be applied to all outbound files.)

Claims File

Flowchart

The following flowchart displays the COBA Claims File Process necessary to create routine production claims files for Trading Partners.


COBA 837 Claim Process
4/20/2005
Faciledi Servers
FI/ Carrier Flat Files
COBA subsystem edits
Pass
Gentran Mapper
Claredi
Compliance checker
X12 Wrapper
COBA Subsystem
fail
COBA subsystem DB
NO
Compliant Claims
Transmit 837 X12files to TP's
Yes
FI/Carrier Repair Report
Invoice Data Feed
FI/Carrier Flat File Error Reports
Dispute Tracking System
TP 837 files
Disputes
Trading Partners
Craft Financial system

Claims File

Formats

The COBC will forward all COBA claims in the following American National Standards Institute (ANSI) X12N file formats—ANSI 837 Version 4010A1 (Institutional) and ANSI 837 4010A1 (Professional)—and the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format for drug claim transactions.

The following Guides provide comprehensive technical details for HIPAA implementation. They define the specific activities related to each transaction and directions for how data should be moved electronically from one entity to another according to HIPAA electronic standards requirements:

- The ASC X12N 837: Professional Implementation Guide
- The ASC X12N 837: Institutional Implementation Guide
- The NCPDP: Retail Pharmacy Transactions

Refer to the Technical Reference section in this guide for the appropriate Web site location.

Frequency

The COBA process will support daily, weekly, bi-weekly, and monthly transfer of claims. The Trading Partner will need to indicate the frequency with which it wishes to receive electronic claims in the COBA Attachment. The Trading Partner may also specify the day (for weekly or bi-weekly) or date (for monthly transfer) that it wishes to receive claims. However, the time of day cannot be specified.

Additionally, the Trading Partner must provide 15 days advance written notification to the COBC for any modifications to its existing COBA claims selection criteria.

Claims File

Claims Selection Options
The Trading Partner may specify different criteria of claims to receive and exclude per COBA identifier.

A. FI/RHHI – Type of Bills

B. FI/RHHI – Type of Claims
Section IV of the COBA Attachment, Claims Selection Options, will allow the Trading Partner to include specific types of claims by provider state or provider identification number for Part A/RHHI claims and by provider state for Part B/DME/RRB claims.

C. DMERC
Section IV of the COBA Attachment, Claims Selection Options, will allow the Trading Partner to exclude specific DMERC regions.

D. Common Claim Types
There is also a method to exclude National Council Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claims.

Notification Timeframes for Non-Receipt, Indecipherable, and/or Damaged Claim Files

Electronic transmissions
The receiving party shall have seven (7) business days from the expected date of transmission to notify the sender by telephone that a Claim File was not received. The receiving party shall have seven (7) business days from the date of transmission to notify the sender by telephone that a Claim File is not readable. The sender shall send a duplicate Claim File to the receiving party, at no additional cost, within five (5) business days from the date of notification by the receiver that the previously transmitted Claim File was not received or not readable.

NOTE: While the receiving party has seven (7) business days from the expected date of transmission to notify the sender that a Claim File was not received to avoid being invoiced for the missing Claim File, the receiving party may notify the sender of the non-receipt of a Claim File no later than the invoice due date. However, a delay in notification until the invoice due date may result in submission of a claim for reimbursement from the provider.

Non-electronic claim files
The receiving party shall have seven (7) business days from the estimated date of receipt to notify the sender by telephone that a Claim File was not received. The receiving party shall have seven (7) business days from the date of receipt to notify the sender by telephone that a Claim File was not readable or damaged. The sender shall send a duplicate Claim File to the receiving party, at no additional cost, within five (5) business days from the date of notification by the receiver if the previously mailed Claim File was not received, was not readable, or was damaged.

NOTE: While the receiving party has seven (7) business days from the estimated date of receipt to notify the sender that a

Claims File

Claim File was not received to avoid being invoiced for the missing Claim File, the receiving party may notify the sender of the non-receipt of a Claim File no later than the invoice due date. However, a delay in notification until the invoice due date may result in submission of a claim for reimbursement from the provider.

Coordination of Benefits Agreement (COBA)

Technical References

Implementation User Guide

TECHNICAL REFERENCES

837 Implementation Guides

The standard ANSI ASC X12N formats have been published and are available at Washington Publishing Company at http://www.wpc-edi.com.

NCPDP Implementation Guides

The NCPDP Web site www.ncpdp.org contains information on NCPDP implementation guides.

Companion Guides

The standard Institutional, Professional, and NCPDP Coordination of Benefits (COB) Companion Documents are available on the Internet at http://www.cms.hhs.gov/manuals/pm_trans/R83OTN.pdf.

Claims Adjustment Reason Codes and Remittance Advice Remark Codes

The following HIPAA required codes are available on the Internet at Washington Publishing Company at http://www.wpc-edi.com.

- **Claim Adjustment Reason Codes**: These codes communicate why a claim or service line was "adjusted" (or paid differently that it was billed).

- **Remittance Advice Remark Codes**: Remark Codes add greater specificity to an adjustment reason code.

COBC Web Site

For more information regarding the COBA Program and to stay connected on any updates/changes, visit our Web site at www.cms.hhs.gov/medicare/cob. The COBA and Implementation User Guide can be found on COBC's website at http://www.cms.hhs.gov/medicare/cob/coba/coba.asp.

Coordination of Benefits Agreement (COBA)

COBA FINANCIAL

Implementation User Guide

COBA Financial

COBA FINANCIAL

The following pages include an extensive information package on electronic billing. A summary of the COBC online payment system initiative db-eBills, how it works and how to get started is provided. This section includes a description of the system's features and benefits, a sample invoice and payment options.

Coordination of Benefits Agreement
Electronic Billing
Introductory Package

Table of Contents

A. Introduction

Welcome!

Thank you for participating in the Coordination of Benefits Contractors (COBC) online payment system initiative known as db-eBills. This introductory package will provide a complete summary of this payment solution, how it works, and how to get started.

Please read the enclosed information carefully. You, the trading partner, will be contacted by the COBC informing you when to complete all forms listed on the checklist (found in section L) and perform self-registration following the instructions found in section J.

Once you self-register, you will be granted access to the db-eBills online service for purposes of accessing and paying your invoices.

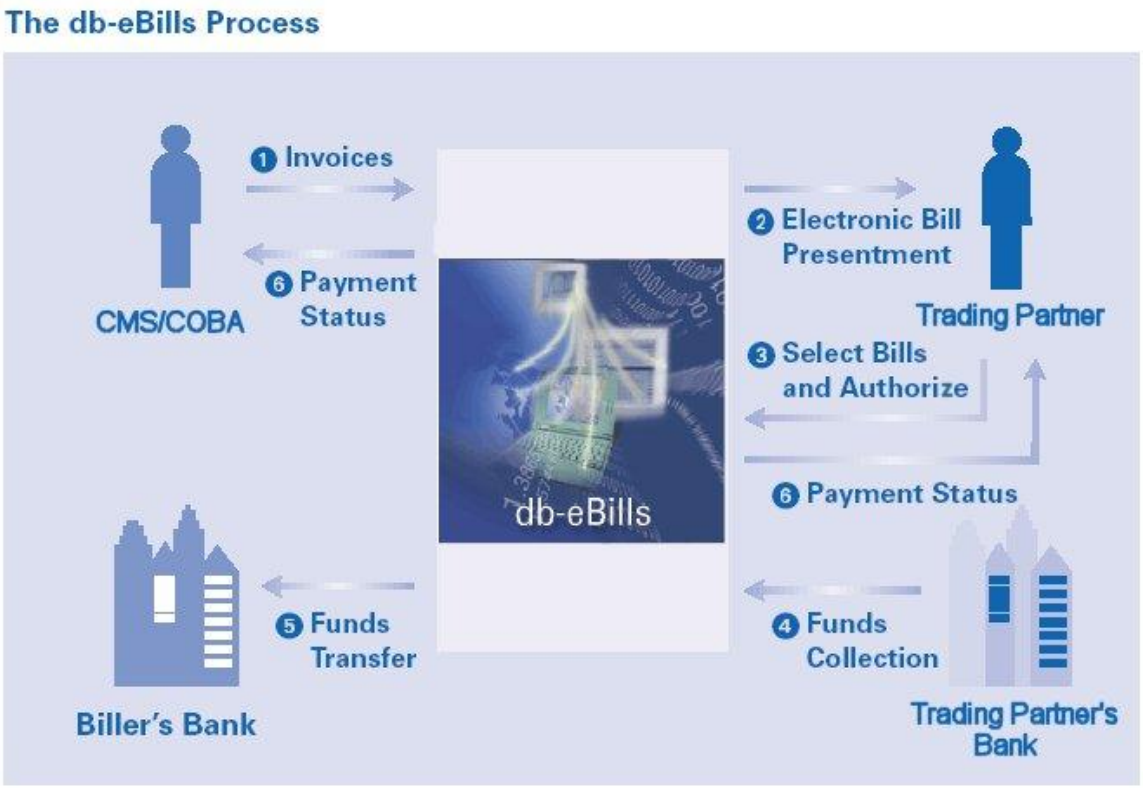
B. What is db-eBills?

db-eBills is an Electronic Invoice Presentment and Payment (EIPP) System. COBC will present your invoices via db-eBills, notifying the trading partner of invoices due. The trading partner will access the invoices online to review, dispute, and authorize payments for crossover claims.

The trading partner decides when to pay, how much to pay, and which bank account and payment method to use. To ensure a high level of security and reliability, db-eBills incorporates the latest state-of-the-art technology and incorporates digital certificates and electronic identity verification mechanisms.

Payments can be made electronically via the Automated Clearing House (ACH) or via check issuance.

C. High Level Overview



Step	Task	Responsibility
1	The EIPP process begins when COBC transmits an electronic file containing invoice data to db-eBills.	COBC
2	Once invoices are successfully loaded, db-eBills will generate an email notification to the trading partner, indicating that the invoices are waiting for its review and approval.	db-eBills
3	When accessing db-eBills, the Trading Partner can perform the following processing actions on these invoices: • View the COBC invoice • Raise disputes on the invoice or line item level • Approve the invoice after checking for validity and accuracy • Perform payment preparation • Apply credit notes to the invoice, if available • Perform payment authorization	Trading Partner
4	Once the payments have been authorized, db-eBills will direct debit your account, through an ACH transaction. The Trading Partner may also issue a check (please remember to include the payment advice, with the check number).	db-eBills
5	Once the funds have been received, db-eBills will credit COBC's account.	db-eBills
6	db-eBills will reconcile the payment information, update the payment status, and inform both COBC and the Trading Partner that funds have been received and that the invoice has been successfully paid.	db-eBills

D. Features and Benefits

Online Access to Bills
With access to timely invoice information, as well as a consolidated view of invoices from different Medicare contractors on one screen, the trading partner can more efficiently manage and control all payments for claim cross-over activities.

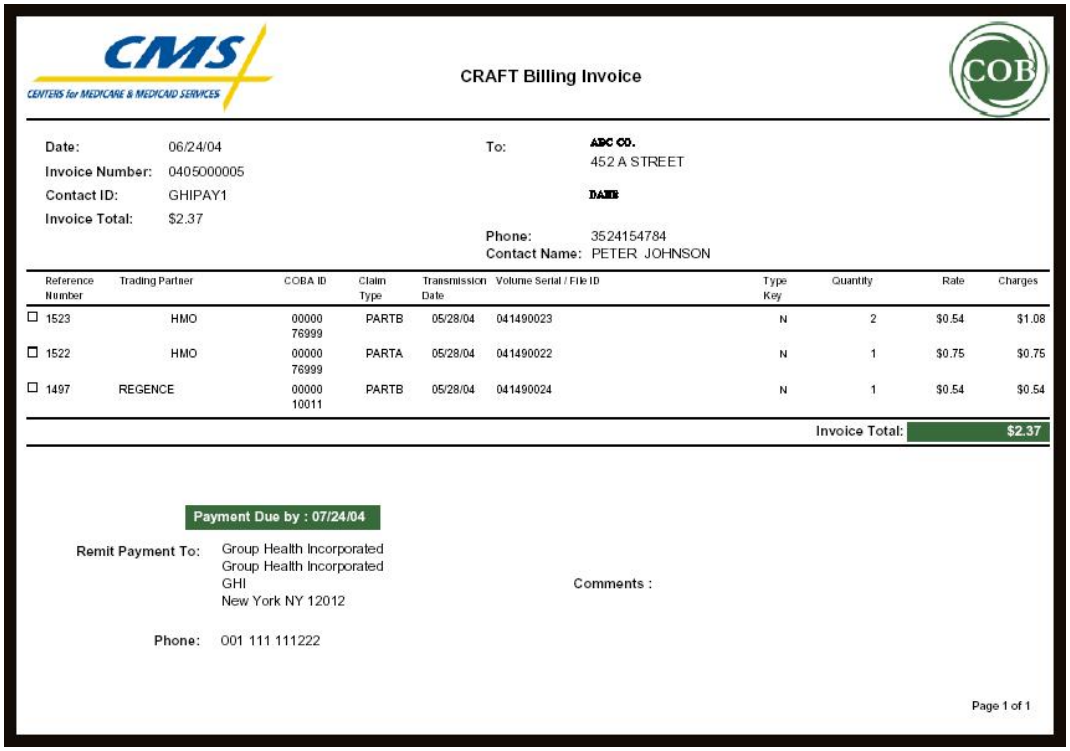
Flexibility and Control for You, the Trading Partner
Using a web browser, the trading partner is able to review and verify invoice details and create payment instructions online. db-eBills is a multi-user system with flexible access rights that can be adapted to the trading partner's existing invoice approval and payment process. This solution also provides the capability for routing invoice information to the responsible departments or individuals for non-financial approval. Furthermore, the trading partner can print bills or integrate the billing information into other accounts payable and Enterprise Resource Planning (ERP) systems.

Fast, Adaptable and Reliable Payments
The trading partner can authorize its payments electronically, eliminating the need to issue and send out traditional payments (e.g., checks), although check payments are certainly accepted. db-eBills supports both single and joint authorization of payments. Different limit categories may be established and managed by the trading partner, in accordance with its internal authorization mandates. For maximum flexibility, db-eBills enables the trading partner to use traditional payment methods or to load billing information into your ERP system.

Online Dispute Resolution
With db-eBills, dispute resolution can now be handled more efficiently online. A trading partner may dispute either whole invoices or specific line items. Standardized dispute codes simplify the process, enabling the trading partner to state the nature of the dispute (e.g., item count, claim type or fee) and identify a reason for the dispute (over-billed, records not received, claim type, etc.).

E. Sample Invoice

The trading partner will now have the ability to view its invoices online. The invoices can be viewed and printed by you. The invoice will look similar to the invoice below:



CRAFT Billing Invoice

Date: 06/24/04
Invoice Number: 0405000005
Contact ID: GHIPAY1
Invoice Total: $2.37

To: ABC CO.
452 A STREET
DATE
Phone: 3524154784
Contact Name: PETER JOHNSON

Reference Number	Trading Partner	COBA ID	Claim Type	Transmission Date	Volume Serial / File ID	Type Key	Quantity	Rate	Charges
1523	HMO	00000 76999	PARTB	05/28/04	041490023	N	2	$0.54	$1.08
1522	HMO	00000 76999	PARTA	05/28/04	041490022	N	1	$0.75	$0.75
1497	REGENCE	00000 10011	PARTB	05/28/04	041490024	N	1	$0.54	$0.54

Invoice Total: $2.37

Payment Due by : 07/24/04

Remit Payment To: Group Health Incorporated
Group Health Incorporated
GHI
New York NY 12012

Comments :

Phone: 001 111 111222

Page 1 of 1

F. Payment Options

The trading partner will have two payment options (ACH or Check):

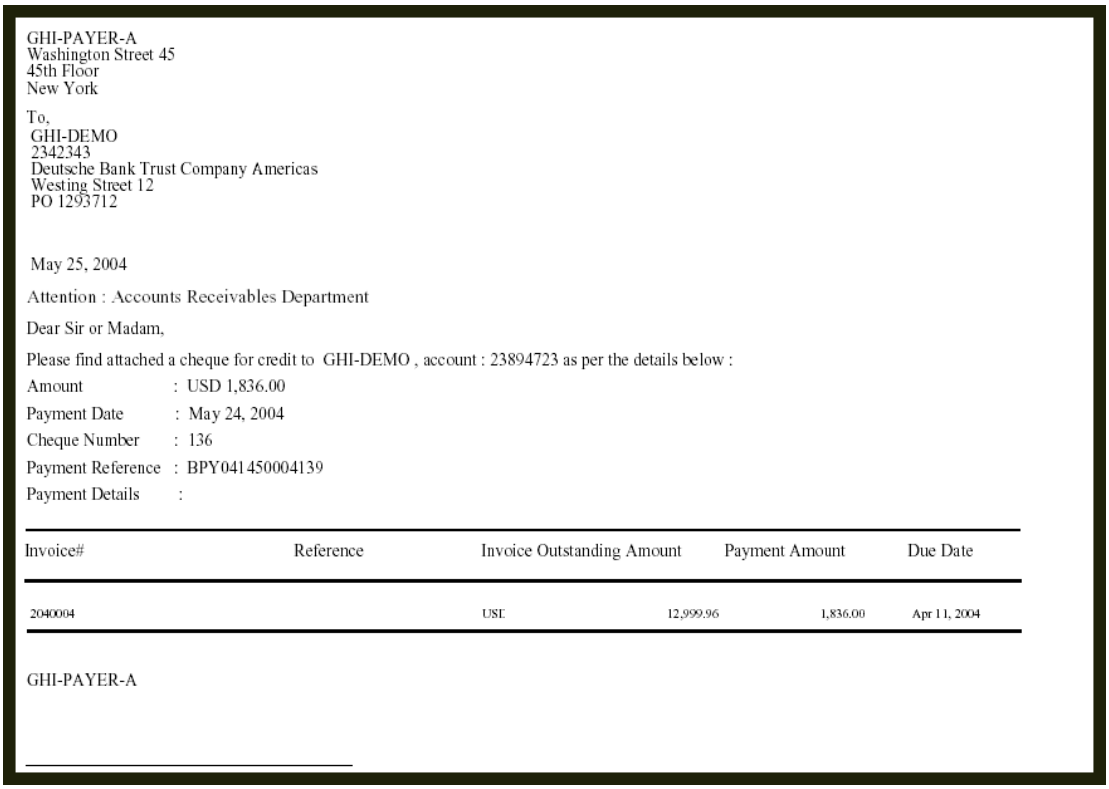
ACH Payments

Automated Clearing House (ACH) is the processing of electronic credit, debit and zero dollar remittance transactions to checking, savings, loan and general ledger accounts nationwide. Regardless of destination/endpoint, an ACH transaction can settle by the next business day. System flexibility and regulations allow for errors to be pulled back within a five day window, as well as returning received ACH transactions that the trading partner does not want, within a specified time period. The network is fully automated, secure, and reliable and has been since 1972. ACH is an efficient method of effecting payments to/from consumers, business partners, vendors and corporations in a very cost-effective way. Studies conducted by the Federal Reserve and the National Automated Clearing House Association (NACHA) show that processing payments via ACH can reduce payment processing costs by 80% or more.

Check payments

The trading partner will still be able to issue check payments off-line, as you normally do. However a db-eBills payment advice must be attached to the check and mailed to COBC.

Below is a sample of the payment advice, which is printed from db-eBills.



GHI-PAYER-A
Washington Street 45
45th Floor
New York

To,
GHI-DEMO
2342343
Deutsche Bank Trust Company Americas
Westing Street 12
PO 1293712

May 25, 2004

Attention : Accounts Receivables Department

Dear Sir or Madam,

Please find attached a cheque for credit to GHI-DEMO , account : 23894723 as per the details below :

Amount : USD 1,836.00
Payment Date : May 24, 2004
Cheque Number : 136
Payment Reference : BPY041450004139
Payment Details :

Invoice#	Reference	Invoice Outstanding Amount	Payment Amount	Due Date
2040004		USI 12,999.96	1,836.00	Apr 11, 2004

GHI-PAYER-A

ACH is the preferred method, as it is:

- **Automated** – The trading partner will initiate and authorize payments online. The trading partner's account will be debited automatically, no more paper.

- **Easier** – No need for the trading partner to have its Accounts Payable issue checks. The trading partner provides the authorization and its account will be debited.

- **Faster** – Once the trading partner is setup for ACH, it simply indicates how much it wishes to pay (online); it then authorizes the payment and its account is debited for the amount approved.

- **More efficient** – ACH will allow a very large amount of remittance information to be transmitted with the ACH payment, streamlining payable and receivables processing. It also supports large dollar transfers, up to $99,999,999.99 per transaction.

- **Better cash management and forecasting** - Settlement date is specified on an ACH transaction.

- **Less expensive** – ACH is 80-90% cheaper then checks. The trading partner will also avoid the processing costs (i.e., insufficient funds fees for returned checks).

G. ACH setup form

In order to be setup on db-eBills, using the ACH payment option, the trading partner must complete and return the ACH Setup form (found in Appendix A).

H. Frequently Asked Questions

Q. Do we have to use db-eBills?
A. Yes, we encourage the use of db-eBills because it provides a more efficient and secure way of making payments.

Q. What is db-eBills?
A. db-eBills is an Electronic Invoice Presentment and Payment (EIPP) System. COBC will present your invoices via db-eBills, notifying you of payments due. You can access invoices online to review, dispute and approve transactions.

You can decide when to pay, how much to pay, and which bank account and payment method to use. To ensure a high level of security and reliability, db-eBills incorporates digital certificates and electronic identity verification mechanisms.

Payments can be made electronically via ACH or via check issuance.

Q. What are the minimum hardware requirements to use db-eBills?
A. Minimum 20MB of available hard-disk space
Monitor capable of 800x600 resolution, though 1024x768 is recommended for better user experience.

Minimum of 256-colors, but 16 million colors are recommended for better resolution.

Internet Access – Dial-up modem (minimum recommended speed is 56 kbps)/Leased Line.

Q. What are the minimum software requirements for db-eBills?
A. Microsoft Windows 98 Second Edition, Windows NT 4.0 with Service Pack 4 or above, Windows ME, Windows 2000, Windows XP.

These OS platforms are supported as per Microsoft's support schedule.

In addition, you will need the following Helper applications: Microsoft Excel 97 or above and Adobe Acrobat Reader Version 4.0 or above. You can download Adobe's free Acrobat Reader at http://www.adobe.com.

Q. What are the web browser requirements?
A. The browser should support high encryption 128 bit SSL. It is recommended that all security patches recommended by IE and Netscape be applied as and when they are announced.

The minimum requirements are:
- Internet Explorer Version 5.5 and above.
- Netscape Navigator Version 6.0 and above.
- You may have to install and enable the latest Java plug-in, which can be downloaded from http://java.sun.com/downloads/.

Q. How much does db-eBills cost?
A. There is no charge for you to use db-eBills as a Trading Partner. COBC will not charge you for this service; however, if you choose to make check payments, you will continue to pay the costs associated with that process. If you choose to make ACH payments, your financial institution may levy a per item charge for each debit to your account. However, the ACH fee should be much lower then the check charge, hence our recommendation to use ACH.

Q. Can db-eBills be accessed outside my office?
A. db-eBills is an Internet browser-based platform and merely requires a previously issued user ID and password to access the system. Therefore, the system can be accessed outside the office. We advise users to clear the cache if the PC does not belong to the user or the PC is accessible by another user.

Q. Who can access db-eBills?
A. The db-eBills system can differentiate between a system administrator, departmental approver, a payment preparer, and authorizer. The specified roles are defined by you, the trading partner, during the setup process and may be assigned to the same user, depending on the size of the organization or established company guidelines.

Role:	Responsibility:
System Administrator	Responsible for creating and managing users. He or she is also responsible for maintaining the organization's business rules environment within db-eBills.
Departmental Approver	Approve, dispute or keep invoice items pending.
Payment Preparer	Responsible for creating a payment once the invoice has been approved. Credit notes may also be used to offset against invoices or debit notes.
Payment Approver/Authorizer	Responsible for authorizing payments, which are created by the payment preparer. Only the respective authorizer with the sufficient authorization limits receives notification upon request of authorization.

Q. How does a user get access to the system?
A. The user ID and password are issued by your system administrator. The initial Trading Partner system administrator is set-up by you yourselves. The passwords of the system administrators are delivered through email to the new users. In order to protect the users, the user would be forced to change the password on first login. In addition, the user is prompted a pre-agreed challenge question in the event that a user is unable to login.

Once your system administrators are setup, your users can be setup through the same procedure. If email is not readily available, the system administrator can print the user ID and password and pass it to the user directly.

Q. What are the password rules?
A. The system enforces the following rules for passwords:

- Minimum of eight alpha-numeric characters, with at least one numeric character. A maximum of two characters can be repeated twice.
- Forced password change every 60 days or on request when a compromise is suspected.
- The new password on a password change cannot be any of the last 12 passwords used by the user.

The system automatically disables a user if that user makes more than three invalid login attempts to login into the system.

Q. How does db-eBills ensure that my data cannot be seen by another organization?
A. db-eBills has incorporated a variety of measures that ensures all user information is kept confidential and secure, in order to detect and prevent unauthorized access and misuse of the system. We employ online user ID and password verification technology to authenticate that the correct user accesses the system. The data are partitioned by customer and filtered before it is presented to a user.

Q. Can we set-up levels of approval?
A. Yes, multiple levels of approval can be setup to accommodate your internal authorization structure.

Q. How secure is the process of online payments in db-eBills?
A. db-eBills is configured so that online transactions involving value transfers (financial transactions) are authorized using two-factor authentication based on industry standard RSA private/public key technology based on cryptography standards. The length of the key is 1024 bits. The private key may be stored on an external portable device (a physical token) that can be removed from the PC when not in use. The authorizer must keep the physical token secure at all times and not disclose the password to prevent misuse. The physical token can only be used in conjunction with the login of the authorizer's user ID and password.

The payment authorization process is digitally signed to ensure non-repudiation. All actions performed in db-eBills are logged as part of the audit trail.

Q. What is a certificate?
A. Digital Certificates reflect credentials of the specific users and are stored electronically within the certificate, similar to a passport. The certificate in db-eBills is used to sign the payment authorization transactions in db-eBills. The digital certificates can be stored in floppy diskettes or hard drive, depending on the necessity within your organization.

Q. How do we add or delete new users?
A. The system administrator is responsible for adding and deleting users.

Q. Is there a limit on the number of users we can add to the system?
A. No.

Q. Are we able to view reports?
A. Yes, the following reports are available to you within db-eBills:

Transaction Reports:
Payer Cash Flow
Non-Financial Inquiry
Credit Notes
Financial Inquiry
Payer Disputes

Administrative Reports:
User Role and Function Report
Report of Blocked Users
Organization Role Report
Organization Access Failure Report

Q. Can we send db-eBills payments on weekends or on a public holiday?
A. Yes, you will have access to db-eBills during weekends and public holidays and you can initiate and approve transactions; however, these transactions will not be processed for payment until the next business day.

Q. Is there online training for db-eBills?
A. Online training is not available at this time.

Q: What is ACH and how does it work?
A. ACH is similar to direct deposit. With direct deposit, your payment is deposited into your bank account automatically. With ACH, your bills are paid from your bank account automatically.

Q: Is ACH new?
A. No, ACH has been a highly reliable and confidential payment method for more than 25 years and uses the same network as direct deposited is much more secure and confidential than checks.

Q: Who benefits from ACH?
A. Everyone benefits from ACH. Companies and individuals save time, hassle, and money. ACH ensures that your payments are confidential and received on time.

Since ACH is more efficient than checks, businesses and the nation's payment system benefit as a direct result. In addition, ACH saves companies an average of 11.5 cents per item (relative to checks) due to reduced processing costs. The country benefits by having fewer

checks that can get lost or stolen. ACH also helps companies improve their cash flow, save time, and enhance customer service.

Q: How many people use ACH?
A. According to the, National Automated Clearinghouse Association, 43 percent of all US households use ACH for at least one recurring payment.

Q: Will companies save money by using ACH?
A. Yes. ACH could save American companies many millions of dollars a year in postage costs. Companies also will save the cost of late fees incurred when checks are mailed or received a couple days late.

Q: What are the company protections with ACH?
A, Regulation E and the NACHA Operating Rules regulate direct deposit and ACH. Among other protections, these rules give companies 60 days to stop or reverse a payment if they believe there is a mistake. In addition, it is the obligation of the biller's bank to make certain that the biller is legitimate. Regulation E also requires companies to notify companies 10 days in advance if the amount of a bill varies from the previous bill. Additional rules pertain to government payments.

Q: If we use ACH, can COBC take extra money from our account?
A. No, Regulation E as outlined in the NACHA Operating Rules protects payers against unauthorized debits from a checking or savings account. It also outlines rules that prohibit a payee from taking money from an account before the date specified and requires the payee to inform the payer 10 days before changing the amount or date of the debit. If a payee mistakenly deducts extra money, Regulation E also provides action steps payers can take to correct the error.

Q: Can COBC see how much we have in our account?
A. No, with ACH, companies never have access to your bank accounts. ACH simply authorizes your bank to automatically release your payment to your biller's financial institution.

Q. Can I be setup to send ACH and check payments?
A. Yes.

Q. If we decide to make payments via check, who should we make the check out to?
A. The check should be made out to: GHI-Medicare/COBC

Q. How do we get started?
A. Simply complete the attached ACH Electronic Coordination of Benefits Agreement (COBA) Credit Authorization Form, authorizing COBC to initiate payment directly from your bank account. The authorization will require your account number and the routing number of your bank. With your authorization, COBC will instruct its financial institution to debit your account on the due date of the bill. When that happens, the payment is automatically released from your bank account on the payment due date. This withdrawal is easy to track because it shows up on your monthly bank statement.

Q. How long does it take to setup?
A. Once you perform self-registration online and return your ACH setup form, it will take approximately 2 days before you receive your Welcome Package. You will be contacted shortly thereafter, to schedule training.

Q. Who can access to the system?
Only the users of an organization, using their logon id and password, will be able to access the system. It's important to remember that your password should not be shared and should be kept confidential. This information is an important means of protection for you. Never write it on your PC or any computer materials.

Q. How can the password be delivered for new users?
The passwords for use can be delivered over email to new users. In order to protect the users, the user would be forced to change the password on first login. In addition, the user would be prompted by a question (such as mother's maiden name) that has to be answered the same way as in the application form for getting a user ID in the system. While email delivery of passwords are extremely efficient, password mailer option is also available on selective basis for an organizations that prefer mailers.

3. Password Rules

The system enforces the following rules for passwords:

-Minimum of 8 alpha-numeric characters, with at least one numeric character. A maximum of 2 characters can repeat twice.
-Forced password change every 90 days (or) on request when a compromise is suspected.
-The new password on a password change cannot be any of the last 12 passwords used by the User.
-Easy to guess passwords (like word password, Deutsche Bank etc.) are blocked.

The system automatically disables a user if that user makes more than 3 invalid login attempts to login into the system.

4. Password Storage

The passwords stored in the system are one-way encrypted. If a password is forgotten, the holder of that forgotten password needs to ensure that a new one is issued. There is no means of decrypting the stored password to its clear text value.

5. Digital Certificates

The db-eBills system supports PKI infrastructure for ensuring transaction security. This ensures the following:

Knowing with whom you are doing business (authentication).

Knowing that the information is kept private during transmission over the public internet (privacy).
Knowing that the information has not been changed during transmission over public internet (integrity).
Knowing that only the parties involved have access to the information (authorization).
Knowing that one party cannot deny having participated in the transaction (non-repudiation).
Knowing that the transaction is actionable and legally valid (digital signature).

Digital Certificates can be used to sign the payment authorization transactions in db-eBills. The digital certificates are issued by Deutsche Bank and are compliant with open standards (X.509 v3). The entire PKI infrastructure adheres to PKCS standards. The digital certificates can be stored in floppy diskettes or smart cards, depending on the necessity within the organization.

While usage of digital certificates is recommended, it is not mandatory to use it within db-eBills. Organizations that require a low cost solution can use passwords for payment authorization.

6. Session Handling

To access db-eBills, the user is required to have a browser that supports 128 bit SSL connection. Secure Socket Layer (SSL) helps provide secure transmission of information along the Internet by encoding the transmitted data using a mathematical formula to scramble the data. Without a corresponding "decoder," the transmission would look like nonsense text and would be unusable. All information from the browser is encrypted before transmission and decrypted on the server (db-eBills system). Similarly, the information from the server is encrypted before transmission and decrypted by the browser client before display.

The effectiveness (or level of security) for encryption is measured in terms of how long the key is – i.e., the longer the key, the longer it would take for someone without the correct "decoder" to break the code. This is measured in bits (e.g., 40-bit encryption and the now increasing preferred 128-bit encryption, which represents the level of encryption required to use db-eBills). A 128-bit encryption is trillions of times more powerful (stronger) than 40- bit encryption.

7. Verifying that the pages belong to db-eBills from Deutsche Bank

In an SSL session, the browser verifies the digital certificate of the server. This digital certificate contains web server address information that is digitally signed (db-eBills certificate is signed by Verisign). The web browser compares and confirms that the website it connected to matches with the digital certificate information. This can be confirmed by the user clicking on the lock or key icon available in the status bar of the browser.

8. Usage of Cookies

A Cookie is a small piece of information that an Internet site sends to your browser to hold onto until it is time to read it. Cookies can contain expiration dates and specific instructions on which web sites can read them. db-eBills uses Cookie technology as a means to store only the user id you use to connect to db-eBills. This information is stored on your computer's hard drive. Under

no circumstances does db-eBills store your password locally on your computer. Users need to enter the password each time they attempt to connect to db-eBills.

9. Inactivity Timeout

The user session is automatically timed out after 15 minutes of inactivity. This time limit can be reduced to a number between 1 and 15 for organizations that choose to have tighter security. db-eBills checks for any inactivity and prompts the users about the session time out 3 minutes before the actual expiry.

10. Concurrent Logins

A user is allowed to login in using the user ID only from one terminal or browser. If the same user logs in from another machine, the first login session is automatically terminated and the new login session is activated.

11. Last Login Information

When a user logs into the system, the last login information (date and time) and the number of bad logins if any are displayed. This helps user to re-confirm that no other person has logged into the system with the user's ID.

12. Periodic Penetration Testing

The Deutsche Bank data center infrastructure is continuously monitored for network "loop-holes." This testing is conducted by accredited external agencies such as Trusecure. Any network and other infrastructure "weaknesses" are managed and controlled.

13. Active Load Balancing and Disaster Recovery support

All critical components of the machine have active load balancing support, whereby the second machine takes over the load of the first machine on failure of the first machine.

A separate exclusive Disaster Recovery site (in a different data center location) is available for take over. Deutsche Bank's stringent business continuity guidelines ensure that business down time on disaster is as minimal as possible.

14. Access to our URL

When a user accesses the db-eBills website, the Internet session is restricted to secure SSL 128-bit strength encryption and is applied to secure data transmitted between the user’s PC and Deutsche Bank.

15. Access to information (status invoice, etc.)

The bank has incorporated a variety of measures into db-eBills that ensures all user information is kept confidential and secure. These measures are also used to detect and prevent unauthorized access and misuse of the system. We employ online user ID and password verification technology to authenticate that the correct user accesses the system. The data are partitioned by customer and filtered before they are presented to a user.

At the organization level, a biller can only view information pertaining to bills that have been issued by that organization. However, a payer can view bills from various billers that have been invoiced to that payer organization only. Furthermore, at the user level, access to invoice information is based on roles. Roles are assigned to a user when the user is created by the administrator.

16. Storage of the information

db-eBills is a browser based application which does not store confidential information in the local PC. All information is stored in the db-eBills database. The database is located in a secure server within the data center. The database does not have any direct connection to the internet.

All connections to the database are audited and periodically reviewed. The database access is restricted to only the system administrators and there is an extensive data center security and policy guideline that needs to be adhered to before a database administrator can have access to the database. Some of the sensitive information such as passwords are hashed and encrypted - and therefore cannot be directly read.

17. Should the payer choose to use debit on demand (direct debit), what is the authorization process and security features in terms of authorization

db-eBills is configured so that online transactions involving value transfers (financial transactions) are authorized using two factor authentication based on industry standard RSA private/public key technology based on public key cryptography standards. The length of the key is 1024 bits. The private key may be stored on an external portable device (a physical token) that can be removed from the PC when not in use. The authorizer must keep the physical token secure at all times and not disclose the password to prevent misuse. The physical token can only be used in conjunction with the login of the Authorizer's User ID and Password.

The payment authorization process is digitally signed to ensure non-repudiation. All actions performed in db-eBills are logged as part of the audit trail.

18. How safe is debit on demand? Can anyone go into the e-bill system and make payments to anyone else other than Biller?

db-eBills only allows payments to pre-determined customer accounts which is set-up by the bank administrator based on biller's instructions. Payers cannot modify or change the beneficiary information. Therefore, they cannot pay any one else other than Biller.

Before the payer can select a debit on demand as a payment option within db-eBills, proper direct debit documentation must be submitted and the relevant account information and direct debit mandate needs to be set-up in the system.

19. Access to db-eBills, information, and transmission of data

To access db-eBills, the user is required to have a browser that supports 128 bit Secure Socket Layer (SSL) connection. SSL helps to provide secure transmission of information along the Internet by encoding the transmitted data using a mathematical formula to scramble the data. Without a corresponding "decoder," the transmission would be unreadable and unusable. All information from the browser is encrypted before transmission and decrypted on the server (db-eBills system). Similarly, the information from the server is encrypted before transmission and decrypted by the browser client before display.

The effectiveness (or level of security) for encryption is measured in terms of how long the key is – i.e., the longer the key, the longer it would take for someone without the correct "decoder" to break the code. This is measured in bits (e.g., 40-bit encryption and the now increasing preferred 128-bit encryption, the level of encryption required to use db-eBills). A 128-bit encryption is trillions of times more powerful (stronger) than 40- bit encryption.

I. How do we get started?

1. Complete ACH setup form if you prefer to send payments via ACH. This can be found in your COBA Implementation User Guide at the end of this section.
2. Perform self-registration online by completing the Financial Profile form
    - Log onto the DB website at dbebills@bd.com
    - Enter your registration code provided within your COBA profile package
3. Once the registration information has been received by COBC, you will be setup on db-eBills within two days.
4. A Welcome Package will be sent to you which will include all user IDs and passwords.
5. COBC will contact you to schedule a training appointment.
6. Participate in training.
7. Begin to receive invoices electronically.
8. Begin to make payments via db-eBills.

Checklist

- Have you received your db-eBills Registration Code (Provided by the COBC)?
- Do you have a workstation with Internet connectivity and browser installed (follow the guidelines defined in the Frequently Asked Questions (FAQ) section)?

If your answer to the above is "YES," proceed to do *db-eBills Self Registration*.

4. When you entered the correct Registration Code, the Detailed registration screen will appear.
This is where you can register your organization in db-eBills.

Register Organization

1. Access the db-eBills system, by entering the following URL: https://dbebills.db.com/ on your browser.

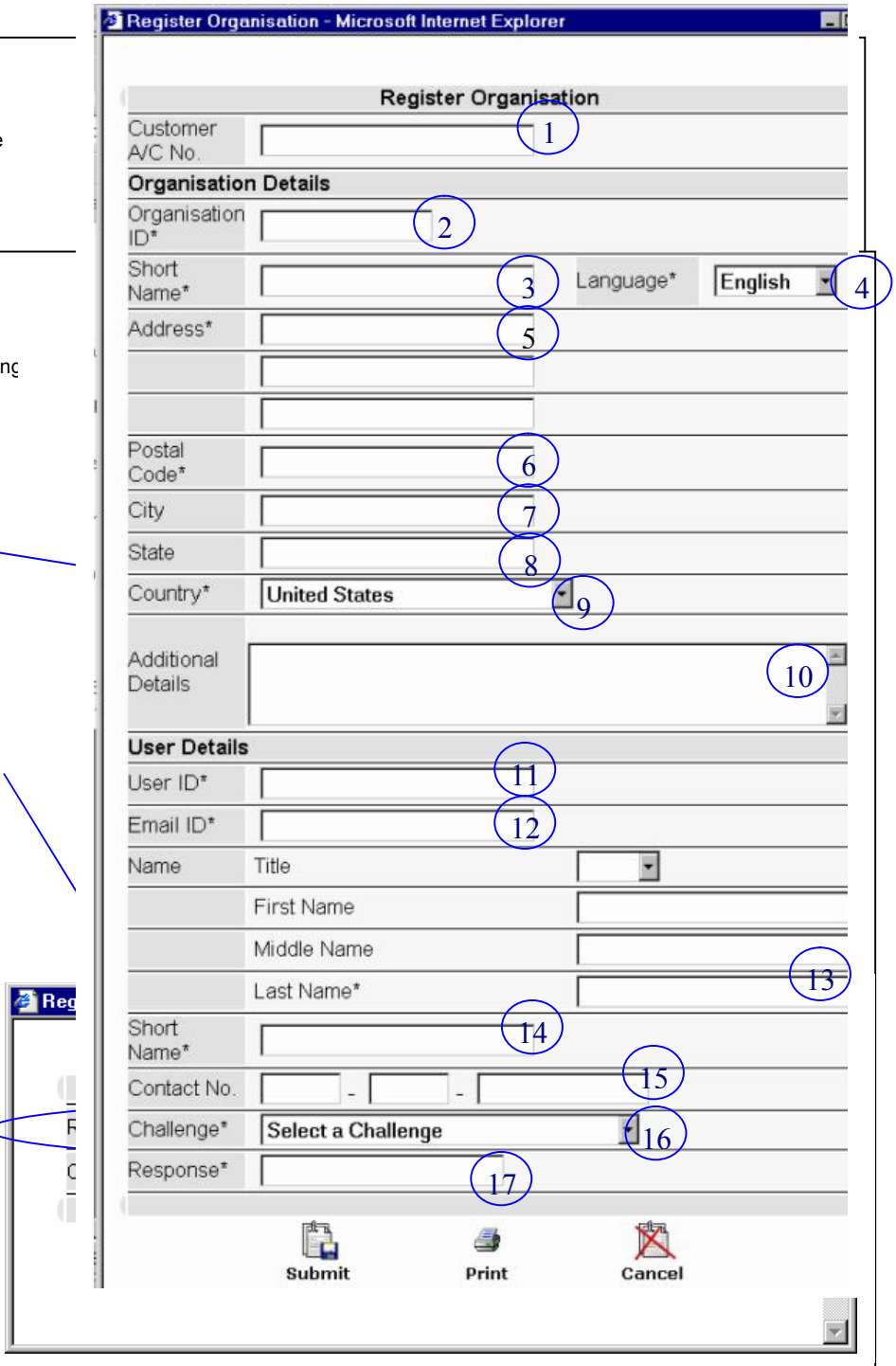
2. Click on the "**Register**" hyperlink.
The Register Organization window will pop-up.

3. Enter your db-eBills Registration Code (which is your XXX ID provided in your COBA Introduction Package)

You are not required to enter the Customer A/C No.

Click "**Next**" to continue.

Please contact COBC, if you receive an error message



As soon as COBC completes the approval process, an email notification will be sent to the Security Administrator email address, informing them that setup is complete.

B.) Organization Details - Field Description:			
2	Organizational ID		This Organization ID will be used in the system
3	Short Name		Short name of your organization
4	Language		Select English for your organization
5	Address		Enter your street address
6	Postal Code		Enter your zip code
7	City		Enter your city
8	State		Enter your state
9	Country		Select your country
10	Additional Details		You may enter additional information, which will be sent to COBC
C.) User Details – Enter the name of the Security Administrator for your company			
11	User ID		This is the log-in ID for the Security Administrator
12	Email ID		Enter the email address for the Security Administrator. The initial password and email notification will be sent to this address
13	Name		Enter the full name of the administrator
14	Short Name		Enter the short name
15	Contact Number		Enter the telephone number of the Security Administrator
16	Challenge		Select the challenge you would to use
17	Response		Follow the prompts to enter the response to the challenge

Important Note: Please keep your Challenge and your Respond to challenge private and confidential.

K. Contact Information

If you have any questions or experience any problems during the setup process, you can contact COBC:

COBC EDI Help Desk
Phone: 646-458-6740
Email: COBVA@ghimedicare.com

MEDICARE - Coordination of Benefits

COBA ACH Electronic Payment Authorization Form

Thank you for choosing to make your claims crossover payments electronically via ACH. ACH allows you to make COBA payments electronically. Here is how the program works:

- Each month, the Coordination of Benefit Contractor's (COBC's) financial institution will automatically debit your designated bank account for the balance due on your invoice.
- Payment is automatically released from your bank account on the payment due date.
- The withdrawal will appear on your monthly bank statement.

To begin the ACH payment program, complete the information requested below and fax to the COBA Accounting Department at 646-458-6761

ACH is regulated by Regulation E and the National Automated Clearinghouse Association's (NACHA) Operating Rules.

Trading Partner's Name _____ **COBA ID** _____

Address _____

City, State, Zip code _____

Name of Contact _____

Contact's E-mail Address _____

Contact's Telephone Number _____

For ACH Payments

Receiving Bank _____

ABA Routing Number _____

SWIFT Address (if applicable) _____

Your Bank Account Number _____

Bank Contact Name and Number _____

What is your preference to receive ACH advice (i.e. electronic or by mail)? _____

If by mail, please provide the mailing address _____

Signature _____ **Date** _____

Please enclose a voided check from the account designated above and verify the accuracy of the information listed before signing.

Coordination of Benefits Agreement (COBA)

CUSTOMER ASSISTANCE

Implementation User Guide

Customer Assistance

CUSTOMER ASSISTANCE

All tapes and correspondence should be forwarded to the following address:

Mailing Address

Medicare-Coordination of Benefits
Attn: COBA Program
PO Box 660
New York, NY 10274-0660

or

Medicare-Coordination of Benefits
Attn: COBA Program
25 Broadway (12th Floor)
New York, NY 10004

(NOTE: This address must be used for all overnight mail deliveries)

Facsimile

Documents can be transmitted to Attn: COBA EDI Department at 1-646-458-6761.

Customer Service

The EDI Department is responsible for coordinating the COBA processes for new Trading Partners. The COBC's EDI representatives are available to provide you with high-quality and efficient service from 8:00 a.m. through 5:00 p.m., Eastern Time (EST), Monday through Friday, except holidays. Contact the EDI Department via e-mail at cobva@ghimedicare.com or call 1-646-458-6740.

Note: Each Trading Partner will be assigned an EDI Representative as its primary contact, and backups will be established in that representative's absence.

ATTACHMENT A

CLAIMS DISPUTE FILE LAYOUT AND SPECIFICATIONS

Layout of Claims Dispute File

When Trading partners process the ANSI X12N 837 COB claims from COBC through their pre editor/translator, some claims may be flagged as errors. Trading Partners may also identify ANSI X12N 837 COB or NCPDP claims that have bad data or should not have been sent to them. Subsequently, the Trading Partners may dispute these claims with COBC.

There are three possible levels of claims disputes for the ANSI 837 files. They are Interchange (ISA-IEA) Level, Transaction (ST-SE) Level, and Claim Level. In the interchange level, all the claims transmitted in the interchange are rejected or disputed. In this case, the Trading Partner should contact the COBC by phone and the corrected interchange would be transmitted to the Trading Partner. At the transaction level, all the claims in a transaction set (ST – SE envelope) are rejected or disputed. Again, the Trading Partner should contact the COBC via email if this occurs. COBC will resend the corrected transaction set(s) to the Trading partner. When claims are rejected or disputed at a claim level, the Trading Partner is required to provide claim level information to COBC via the dispute flat file.

Since NCPDP claims are not in the HIPAA 837 COB format, the dispute levels are slightly different. There are three possible levels of claims disputes for the NCPDP files. They are Batch Level, Transmission Level, and Claim Level. At the Batch level, all the claims transmitted in the Batch are rejected or disputed. This could occur if an error occurs in the batch header or batch trailer. At the transmission level, all the claims associated with a Patient or an Insurance segment are rejected or disputed. This can occur when an error is encountered in the Transmission Header, Patient Record, or Insurance segments. For either of these scenarios, the Trading Partner should contact the COBC by phone and the corrected Batch or Transmission set(s) will be transmitted to the Trading Partner. A claim (transaction) may be rejected or disputed when an error is encountered in any of the transaction level segments (Claim, Pricing, Pharmacy Provider, Prescriber, COB/Other Payments, Workers Comp, DUR/PPS, Coupon, Prior Authorization, Clinical). When claims are rejected or disputed at a claim level, the Trading Partner is required to provide claim level information to COBC via the dispute flat file.

When disputing claims, Trading Partners must supply COBC with information on the data being disputed to enable an investigation of those claims. This information is used to locate and review the data in the COBC files. A claims dispute/error file contains a Header record, one or more Detail records and a Trailer record. This data is submitted in a flat file as specified below. Even though multiple errors can occur in a claim, the Trading Partner should send only one Detail record per claim on the dispute file.

Header Record

Field Name	Size / Description	Source Dispute 837	Source Dispute NCPDP
Record ID	*7 bytes - Alpha* This identifies the type of record. It will always contain the word HEADER. This field is left justified.	HEADER Required	HEADER Required
Trading Partner Name	*40 bytes - AN* Name of the Trading Partner	Trading partner name *Required*	Trading Partner name *Required*
Trading Partner Contact ID	*9 bytes – AN* Invoice contact ID of the Trading Partner	Trading partner ID *Required*	Trading partner ID *Required*
Transmit Date	*10 bytes – AN* MM-DD-CCYY Date the dispute / error file was transmitted	Current date *Required*	Current date *Required*
Transmit Time	*8 bytes – AN* *HH:MM:SS* Time the dispute / error file was transmitted	Current time *Required*	Current time *Required*
Trading Partner Dispute Reference ID	*20 bytes – AN* A dispute Reference ID assigned by a Trading Partner to track their disputes.	*Optional*	*Optional*
Dispute File ID	*9 bytes – AN* Dispute File Id assigned by Trading Partner. Must be unique for each file transmitted.	Required	Required
Filler	*409 bytes* ***For future use*** *– should be filled with spaces.*		

Total = 512 bytes

Dispute / Error Detail Record

Field Name	Size / Description	Source Dispute 837	Source Dispute NCPDP
Record ID	*7 bytes - Alpha* This identifies the type of record. It will always contain the word DETAIL. This field is left justified.	DETAIL	DETAIL
COBA ID	*10 bytes – Numeric* *(5 byte IDs are prefixed with 5 zeros)* This contains the COBA ID affiliated with the set of claims	Element NM109 from Loop 1000B *Required*	Element 301-C1 of the Insurance record. *Required*
Claim Type	*5 bytes – Alpha* Describes the type of claim containing the error	PARTA for Institutional PARTB for Professional *Required*	NCPDP *Required*

Field Name	Size / Description	Source Dispute 837	Source Dispute NCPDP
Trading Partner Claim File ID	*9 bytes – AN* The File ID from the Trading Partners' 837/NCPDP file.	Element ISA13 from the ISA header segment. *Required*	Element 806-5C from the Batch Header *Required*
Claim File Transmission Date	*6 bytes – Numeric* *YYMMDD* The date the file was transmitted from COBC	Element ISA09 from the ISA header segment. *Required*	Element 806-5C from the Batch Header. *Required*
HIC Number	*12 bytes – AN* The Medicare HIC number for the claim.	Element NM109 in the 2330A Loop *Required*	Element 332-CY in the Patient Segment *Required*
Claim Number	*14 bytes – AN* The Claim number (ICN, DCN) for the claim	Element REF02 in the 2330B loop when REF01 = F8. *Required*	N/A
Loop ID / Record Type	*6 bytes – AN* Loop ID (837) or Record Type (NCPDP) of the suspect record	Loop ID for the segment in question. *Must be included for errors that occur at the trading partner's PreEditor / Translator*	Record Type of the record in question. *Required*
Segment ID	*3 bytes – AN* Segment Name (837) of the segment in error.	Segment Name for the segment in question. *Must be included for errors that occur at the trading partner's PreEditor / Translator*	N/A
Element ID	*10 bytes – AN* Element Name (837), with sub-element ID of the erroneous element. (e.g. SVD03-2 = Sub-element 2 of SVD03)	Element name for the element in question. *Must be included for errors that occur at the trading partner's PreEditor / Translator*	N/A.
Contractor Reference ID (CRI)	*30 bytes – AN* The ID that is unique to the contractor's submitted file / transaction set.	Element BHT03 in the BHT segment. *Required*	Element 504-F4 in the Batch Trailer. *Required*
Contractor Number	*9 bytes - AN* ID assigned by CMS to the contractor submitting the claim to COBA. If 5 bytes pad last 4 with spaces.	Element NM109 in the 1000A loop. *Required*	Element 340-7C of the Other COB record *Required*
Transaction Set ID	*9 bytes - AN* Identifier of the Transaction assigned by CMS	Element ST02 in the ST segment. *Required for errors that occur at the trading partner's PreEditor/Translator.*	N/A
DB ebills Invoice #	*10 bytes – AN* The Invoice number of the bill that covers the claims in dispute.	Invoice Number for dispute. *Required when disputing invoiced claims.*	Invoice Number for dispute. *Required when disputing invoiced claims.*
DB ebills Line Item Ref #	*16 bytes – AN* The line item reference number of the disputed claims – from the ebills.	Reference number of the line on the billed invoice. *Required when disputing invoiced claims.*	Reference number of the line on the billed invoice. *Required when disputing invoiced claims.*
Dispute or Error Reason Code	*6 bytes – AN* The reason for the dispute or error. *This will come from a list of standard error codes.*	Code selected from the reason code list. *Required – Use 009999 if other. See the Dispute reason code table*	Code selected from the reason code list. *Required – Use 009999 if other. See the Dispute reason code table*

Field Name	Size / Description	Source Dispute 837	Dispute NCPDP
Trading Partner Dispute Reference ID	*20 bytes – AN* A dispute Reference ID assigned by a Trading Partner to track their disputes.	*Optional*	*Optional*
Dispute Resolution Code	*15 bytes – AN* *The dispute resolution code assigned by COBC.*	**Reserved for COBC** *Trading Partners leave this field blank.*	**Reserved for COBC** *Trading Partners leave this field blank.*
Comments	*200 bytes – AN* Free form comment	Text to clarify the reason for the dispute. *Required if the dispute reason code is 009999. Otherwise, Optional*	Text to clarify the reason for dispute. *Required if the dispute reason code is 009999. Otherwise, Optional*
Filler	*115 bytes* ***For future and internal use** – should be filled with spaces.*		

Total = **512** bytes

Trailer Record

Field Name	Size / Description	Source Dispute 837	Dispute NCPDP
Record ID	*7 bytes - Alpha* This identifies the type of record. It will always contain the word TRAILER.	TRAILER Required	TRAILER *Required*
Trading Partner Name	*40 bytes - AN* Name of the Trading Partner	Trading partner name *Required*	Trading Partner name *Required*
Record Count	*10 bytes – Numeric* *The number should contain leading zeros.* The count of the records in this Dispute / Error file, including the Header and Trailer records.	Count of records *Required*	Count of records *Required*
Dispute File ID	*9 bytes – AN* Dispute File Id assigned by Trading Partner. Must be unique for each file transmitted.	*Required*	*Required*
Filler	*446 bytes – AN* **For Future Use** – should be populated with spaces		

Total = 512 bytes

- The records that are included in this file are fixed length records, 512 bytes long. All fields should be padded with spaces to the complete field length.
- Fields are separated with a delimiter.
- Each record in a dispute file is terminated by a Carriage return and Line feed.

Dispute Reason Codes

The following table lists all the dispute reason codes currently available. This is the code that is used to populate the Dispute or Error Reason field in the Detail Records.

Reason Code	Dispute Reason
000100	Duplicate Claim
000110	Duplicate Claim (within the same ISA-IEA loop)
000120	Duplicate Claim (within the same ST-SE loop)
000200	Reserved for future use
000300	Beneficiary not on eligibility file
000310	Beneficiary record in transition
000400	Reserved for future use
000500	Incorrect claim count
000600	Claim does not meet selection criteria
000700	HIPPA Error
009999	Other

Example:

An example of the Dispute file is shown in a separate text file.

ATTACHMENT B

Medicare Contractors & Their Associated States

Medicare Contractor Name	*Line of Business*	*Associated States*
AdminaStar Federal	Part A	IN, IL, KY, OH
AdminaStar Federal	Part B	IN, KY
AdminaStar Federal	DMERC	DC, IL, IN, MD, MI, MN, OH, VA, WI, WV
Alabama BC (Cahaba)	Part A (including RHHI)	For Part A (non RHHI): AL, ID, SD For RHHI: CO, DC, DE, IA, KS, MD, MO, MT, ND, NE, PA, SD,UT, WV, WY
Alabama BS (Cahaba)	Part B	AL, GA, MS
Anthem Health Plans of New Hampshire & Vermont	Part A	NH, VT
Arizona BC	Part A	AZ
Arkansas BC	Part A	AR, RI
Arkansas BS	Part B	AR, LA, MO (Eastern), NM, OK, RI,
Associated Hospital Service (AHS) of Maine	Part A (including RHHI)	For Part A (non RHHI): MA, ME For RHHI: CT, MA, ME, NH, RI, VT
CareFirst of Maryland	Part A	DC, MD
CIGNA (Connecticut General)	Part B	ID, NC, TN
CIGNA (Connecticut General)	DMERC	AK, American Samoa, AZ, CA, Guam, HI, IA, ID, KS, MO, MT, ND, NE, North Marianna Islands, NV, OR, SD, UT, WA, WY.
Cooperativa de Seguros de Vida de PR	Part A	Puerto Rico, Virgin Islands
Empire Medicare Services	Part A	CT, DE, NY
Empire Medicare Services	Part B	NJ, NY
Florida BC (First Coast Service	Part A	FL

Medicare Contractor Name	*Line of Business*	*Associated States*
Options)		
Florida BS (First Coast Service Options)	Part B	CT, FL
Georgia BC	Part A	GA
Group Health Inc. (GHI)	Part B	NY (Queens)
HealthNow of NY (BCBS of Western NY)	Part B	NY (Western)
HealthNow of NY (BCBS of Western NY)	DMERC	CT, DE, MA, ME, NH, NJ, NY, PA, RI, VT
Highmark GSA Administrators	Part B	PA
Kansas BC	Part A	KS
Kansas BS	Part B	KS, MO (Western)
Medicare Northwest (Regence of Oregon)	Part A	ID, OR, UT
Mississippi BC (Trispan Health Services)	Part A	LA, MO, MS
Montana BC	Part A	MT
Montana BS	Part B	MT
Mutual of Omaha	Part A	48/50 states as nominated by the provider.
National Heritage Insurance Company (NHIC)	Part B	CA, MA, ME, NH, VT
Nebraska BC	Part A	NE
Noridian Mutual Insurance Company	Part A	AK, MN, ND, WA
Noridian Mutual Insurance Company	Part B	AK, American Samoa, AZ, CO, Guam, HI, IA, ND, North Marianna Islands, NV, OR, SD, WA, WY
Oklahoma BC (Chisholm Administrative Services)	Part A	OK
	Part A (including RHHI)	For Part A (non RHHI):

Medicare Contractor Name	*Line of Business*	*Associated States*
Palmetto GBA		NC, SC For RHHI: AL, AR, FL, GA, IL, IN, KY, LA, MS, NC, NM, OH, OK, SC, TN
Palmetto GBA	Part B	OH, SC, WV
Palmetto GBA	Part B Railroad Retirement Board	All states
Palmetto GBA	DMERC	AL, AR, CO, FL, GA, KY, LA, MS, NC, NM, OK, Puerto Rico, SC, TN, TX, Virgin Islands
Regence Blue Cross Blue Shield of Utah	Part B	UT
Tennessee BC (Riverbend GBA)	Part A	NJ, TN
TrailBlazer Health Enterprises, LLC	Part A	CO, NM, TX
TrailBlazer Health Enterprises, LLC	Part B	DC, DE, MD, VA, TX
Triple-S, Inc.	Part B	Puerto Rico (PR), Virgin Islands (VI)
United Government Services	Part A (including RHHI)	For Part A (non RHHI): American Samoa, CA, Guam, MI, North Marianna Islands, VA, WI, WV For RHHI: AL, American Samoa, AR, CA, Guam, HI, ID, OR, North Marianna Islands, NV, WA
Veritus Medicare Services	Part A	PA
Wisconsin Physician Services (WPS)	Part B	IL, MI, MN, WS
Wyoming BC	Part A	Wyoming

February 2005

Medicare Contractors' Internal Crossover Contact Directory
February 2005

Contractor	Contact Name (s)	Part A	Part B	DMERC	Phone	E-mail
AdminaStar Federal	Greg Walker	X			502-423-2373	Greg.walker@anthem.com
	Charlene Lange		X	X	317-841-4650	Charlene.lange@anthem.com
Alabama BCBS (Cahaba GBA)	Paula Daw	X	X		205-220-1367	pdaw@bcbsal.org
Anthem Health Plans of New Hampshire & Vermont	Ted Cooney	X			207-253-3688	edward.cooney@anthem.com
Arizona BC	Kellie Mann	X			602-864-4019	kmann@phx1.bcbsaz.com
Arkansas BCBS	Danette Perry	X	X		501-210-9339	crossover@arkbluecross.com
Associated Hospital Service (AHS) of Maine	Ted Cooney	X			207-253-3688	edward.cooney@anthem.com
CareFirst of Maryland	Kenya McEachern-Todd	X			410-561-4299	kenya.mceachern@carefirst.com
CIGNA (Connecticut General)	Larissa Melnikova		X	X	615-782-4500 ext.23508	larissa.melnikova@cigna.com
Cooperativa de Seguros de Vida de PR	Sandra Pena	X			787-758-9733 x-2560	SPena@cosvi.com
	Iris Bonilla	X			787-758-9733	ibonilla@cosvi.com
Empire Medicare Services	Patricia Allen	X	X		315-442-	patricia.allen@empireblue.com

Contractor	Contact Name (s)	Part A	Part B	DMERC	Phone	E-mail
					4626	
	Joyce Cianciola	X	X		315-442-4782	joyce.cianciola@empire.com
First Coast Service Options	Pam Streitler	X	X		904-791-6825	pam.streitler@fcso.com
Georgia BC	Kimmi Durden	X			706-571-5576	kdurden@bcbsga.com Medicare.claims-support@bcbsga.com
Group Health Inc. (GHI)	Jim Brady		X		646-458-6682	jim@ghimedicare.com
HealthNow of NY (BCBS of Western NY)	Leslie Valashinas		X	X	607-766-6534	valashinas.leslie@healthnow.org
	Joann Soules		X	X	607-766-6492	soules.joann@healthnow.org
Highmark GSA Administrators	Robert Burchfield		X		717-302-4275	robert.burchfield@hgsa.com
	Gary Howard		X		717-302-4278	gary.howard@hgsa.com
	John Hestor		X		717-302-3625	john.hestor@highmark.com
Kansas BCBS	Tracey Funk	X			785-291-6964	tracey.funk@bcbsks.com
	LaDawna Richmond (Until June 2005)		X		785-291-7452	Ladawna.richmond@bcbsks.com
Medicare Northwest (Regence of Oregon)	Melodee Robinson	X			503-721-7033	mjrobin@regence.com
	Chris Lane	X			503-721-7094	celane@regence.com

Contractor	Contact Name (s)	Part A	Part B	DMERC	Phone	E-mail
Mississippi BC (Trispan Health Services)	Ann Welch	X			601-664-4397	awelch@bcbsms.com
Mississippi BC (Trispan Health Services)	Jimmy Chaney	X			601-664-4229	jchaney@bcbsms.com
Montana BC	Doris Hernandez	X			406-791-4013	Doris_hernandez@bcbsmt.com
Montana BC	David Pfeifle	X			406-791-4152	David_pfeifle@bcbsmt.com
Montana BS	Jim Schweyen		X		406-447-8703	jschweyen@bcbsmt.com
	Gloria Wels		X		406-444-8995	gwels@bcbsmt.com
Mutual of Omaha	Nancy Miller	X			402-351-7226	nancy-med.miller@mutualofomaha.com
	Jo Ellen Fouts	X			402-351-7249	joellen.fouts@mutualofomaha.com
	Jill Johnson	X			402-351-7250	jill.johnson@mutualofomaha.com
National Heritage Insurance Company (NHIC)	Melinda Edge		X		781-741-3152	melinda.edge@eds.com
	Marilyn Smith		X		213-593-6207	marilyn.smith@eds.com

Contractor	Contact Name (s)	Part A	Part B	DMER C	Phone	E-mail
	Sharon Jacob		X		781-741-3113	sharon.jacob@eds.com
Nebraska BC	Carroll Ferro	X			402-343-3558	carroll.ferro@bcbsne.com
Noridian Mutual Insurance Company	Frank Gartner	X	X		701-277-6836	frank.gartner@noridian.com
Noridian Mutual Insurance Company	Eric Jorgenson	X	X		701-282-1532	eric.jorgenson@noridian.com
Oklahoma BC (Chisholm Administrative Services)	Stan Hooper	X			918-560-3330	shopper@bcbsok.com
	Sandy Gray	X			918-560-3373	sgray@bcbsok.com
Palmetto GBA-North Carolina	Phyllis Jones	X			919-687-7182	phyllis.jones@palmettogba.com
Palmetto GBA—Railroad Part B	Jim Shealy		X		803-763-1596	jim.shealy@palmettogba.com
Palmetto GBA – Ohio and West Virginia	Jim Shealy		X		803-763-1596	jim.shealy@palmettogba.com
	Bernice Steward		X		614-473-6678	bernice.steward@palmettogba.com
Palmetto GBA-South Carolina	Jim Shealy	X	X	X	803-763-1596	jim.shealy@palmettogba.com
	Rhonda Harris	X	X	X	803-763-4621	rhonda.harris@palmettogba.com

Contractor	Contact Name (s)	Part A	Part B	DMERC	Phone	E-mail
Regence Blue Cross Blue Shield of Utah	Sheryl Komis		X		801-333-2290	skkomis@regence.com
	Utah Medicare Part B EDI Help Desk		X		801-333-2290	MedicareB_EDI@regence.com
Tennessee BC (Riverbend GBA)	Ben Thackston	X			423-755-5735	Ben_Thackston@bcbst.com
	Wanda Williams	X			423-755-5803	Wanda_Williams@bcbst.com
	Mike Gibson	X			423-785-8030	Mike_Gibson@bcbst.com
TrailBlazer Health Enterprises, LLC	Kathleen Boyd	X	X		469-372-7416	Kathy.boyd@trailblazerhealth.com
TrailBlazer Health Enterprises, LLC	Michelle Bianchi		X		717-774-2802	Michelle.Bianchi@trailblazerhealth.com
	Keith Johnson	X			469-372-7961	Keith.Johnson@trailblazerhealth.com
Triple-S, Inc.	Freddie Canales		X		787-749-4178	freddiec@exchange.triples-med.org
United Government Services	Ken Ottmann	X			414-226-6150	randall.watkins@cobalt-corp.com
	Judy Radtke	X			414-226-5783	judith.radtke@cobalt-corp.com
	Brian Wendt	X			715-421-4105	brian.wendt@cobalt-corp.com
Veritus Medicare Services	Donna Mandella	X			412-544-1953	donna.mandella@veritusmedicare.com

Contractor	Contact Name (s)	Part A	Part B	DMERC	Phone	E-mail
	Sharon Depenhart	X			412-544-1923	sharon.depenhart@veritusmedicare.com
Wisconsin Physician Services (WPS) for Wisconsin, Illinois, Michigan, and Minnesota	Lynn Reinholtz		X		608-301-2778	lynn.reinholtz@wpsic.com
	Debbie Nowland		X		248-395-7537	debra.nowland@wpsic.com
	Ross Green		X		608-301-2645	ross.green@wpsic.com
Wyoming BC	Adella Duran	X			307-432-2850	Adella.duran@bcbswy.com

Medicare Part A & B 837 HIPAA Claims from COBA:

	ISA INTERCHANGE CONTROL HEADER	
ISA06	Interchange Sender ID	**Literal "COBA" without quotes.**
ISA08	Interchange Receiver ID	**PAYER SUPPLIED ID (specified in the COBA contract)**
ISA13	Interchange Control Number	**EDI 837 FileID (Unique ID for each ISA transmitted)**
	GS FUNCTIONAL GROUP HEADER	
GS02	Application Sender's Code	**Literal "COBA" without quotes.**
GS03	Application Receiver's Code	**PAYER SUPPLIED ID (specified in the COBA contract)**
ST	**Transaction Set Header**	
	LOOP ID - 1000A SUBMITTER NAME	
NM1	Submitter Name (NM101 = 41)	**NM109 WILL CONTAIN THE CONTRACTOR'S MEDICARE ID. (See CMS List)**
	LOOP ID - 1000B RECEIVER NAME	
NM1	Receiver Name (NM101 = 40)	**NM109 WILL CONTAIN THE Payer's COBA ID**
	LOOP ID - 2010BA SUBSCRIBER NAME	
NM1	Subscriber Name (NM101 = IL)	**NM109 CONTAINS THE SUPPLEMENT INSURANCE ID IF THE ELIGIBILITY FILE CONTAINS THE SUBSCRIBER ID. OTHERWISE, MEDICARE HIC# OF THE INSURED**
	LOOP ID - 2010BB (837P) 2010BC (837I) PAYER NAME	
NM1	Payer Name (NM101 = PR)	**NM109 WILL CONTAIN THE Payer's COBA ID**
	LOOP ID - 2330A OTHER SUBSCRIBER NAME	
NM1	Other Subscriber Name (NM101 = IL)	**NM109 CONTAINS MEDICARE HIC# OF THE INSURED**

ATTACHMENT E

HIGH LEVEL ERRORS

837 COB Flat File Process Rules

Part B and DMERC (Professional)

1. The following segments shall not be passed to the COBC:
a) ISA (Interchange Control Header Segment)
b) IEA (Interchange Control Trailer Segment)
c) GS (Functional Group Header Segment)
d) GE (Functional Group Trailer Segment)

2. The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:
a) NM103—Use spaces.
b) NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

3. The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with COBC completing any missing information:
a) NM1 segment—For NM103, NM104, NM105, and NM107, use spaces.
b) NM1 segment—For NM109, include HICN.
c) N3 segment—Use all spaces
d) N4 segment—Use all spaces.

4. The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:
a) NM1 segment—For NM103, use spaces.
b) NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).
c) N3 segment—Use all spaces.
d) N4 segment—Use all spaces.

5. The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be

unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:
a) NM103—Use spaces.
b) NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29). The 2330B loop shall be repeated to allow for inclusion of the Name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

6. The 2320 loop defines other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations. -- SBR01 – treat as you currently do.

Part A (Institutional)

1. As the ISA, IEA, and GS segments are included in the '100' record with other required segments, the '100' record must be passed to the COBC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

2. The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the '100' record:
a) NM103—Use spaces.
b) NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

3. The 2010BA loop denotes the subscriber information. If available, the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the '300' record, with COBC completing any missing information:
a) NM1 segment – For NM103, NM104, NM105, and NM107, use spaces.
b) NM1 segment—For NM109, include HICN.
c) N3 segment—Use all spaces.
d) N4 segment—Use all spaces.

4. The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the '300' record, with COBC completing any missing information:
a) NM1 segment—For NM103, use spaces.
b) NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).
c) N3 segment—Use all spaces.
d) N4 segment—Use all spaces.

5. The 2330B loop of the '575' record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:
a) NM103—Use spaces.
b) NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29). The 2330B loop shall be repeated to allow for inclusion of the Name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

6. The 2320 loop defines other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values

should be propagated accordingly for both current trading partners and COBA trading partners. COBC will inspect these values for COBA related eligibility
based claims and overlay as appropriate. Spaces should only be used for COBA- related situations.
-- SBR01 – treat as you currently do.

837 Institutional Edits by the COBC

Assumption: Intermediaries will forward HIPAA compliant 837v4010A1 flat file layout crossover claims files to the COBC.

Record 100 exists

The value in the field SUBMITTER ETIN is a valid MEDA FI

The value in the field RECEIVER NAME is spaces

The value in the field RECEIVER ETIN is a valid COBA id

Record 200 exists

Record 300 exists

The value in the field SUBSCRIBER PRIMARY ID is a HICN (alpha-numeric and not greater than 12 bytes long)

Spaces in the fields SUBSCRIBER LAST NAME, SUBSCRIBER FIRST NAME, SUBSCRIBER MIDDLE INITIAL, SUBSCRIBER NAME SUFFIX, SUBSCRIBER ADDRESS LN 1, SUBSCRIBER ADDRESS LN 2, SUBSCRIBER CITY, SUBSCRIBER

STATE, SUBSCRIBER ZIP CODE and SUBSCRIBER COUNTRY CODE is valid

The value in the field PAYER NAME is spaces

The value in the field PAYER ID NUMBER is a valid COBA id

The value in the fields PAYER ADDRESS LN 1, PAYER ADDRESS LN 2, PAYER CITY, PAYER STATE, PAYER ZIP CODE, PAYER COUNTRY CODE is spaces

At least one record 500 exists for each record 300

There is no more than 100 record 500s for each record 300

There is at least one record 575 for each record 500

At least one iteration of the record 575 must have field PAYER RESPONSIBILITY SEQUENCE CODE equal to the value of 'P'

There is at least one record 590 for each record 575

If there is only one record 575 (meaning Medicare is the primary payer), the following must be set:

The field PAYER RESPONSIBILITY SEQUENCE CODE is the value of 'P'

The field PATIENT RELATIONSHIP TO INSURED is the value of '18'

The field SOURCE PAY CODE is the value of 'MA'

One of the record 590s associated with record 575 has:

The field OTHER PAYER ID CODE QUAL is the value of 'PI'

The field OTHER PAYER ID NUMBER is equal to the value in the field SUBMITTER ETIN in record 100

The field OTHER SUBSCRIBER/INSURED 2NDARY ID QUAL is the value of 'F8'

The field OTHER SUBSCRIBER/INSURED SECONDARY ID is greater than space (Intermediary's claim control number)

There is at least one record 600 for each record 500

There is no more than 999 record 600s for each record 500

If there is a record 650, the number of record 650s cannot exceed 25 for each record 600. (Assumption: There can only be 25 occurrences of the record type 650 for each record 600.)

For the iteration of record 650 that is the Medicare adjudication information, field PAYER IDENTIFICATION is equal to the Intermediary's number

Record 999 exists

837 Professional Edits by the COBC

Assumption: Carriers and DMERCs will forward HIPAA compliant 837v4010A1 flat file layout crossover claims files to the COBC.
Segment ST exists
Segment BHT exists
Segment REF exists
There is only one iteration of the 1000A loop per ST/SE envelope (record set)
The value in 1000A.NM109 is equal to a valid MEDB or DMERC Carrier ID
There is only one iteration of the 1000B loop per ST/SE envelope (record set)
The value in 1000B.NM103 is equal to spaces
The value in 1000B.NM109 is equal to a valid COBA id
There is at least one iteration of the 2000A loop
There is only one iteration of the 2010AA loop per 2000A loop
There is at least one iteration of the 2000B loop
There is only one iteration of the 2010BA loop per 2000B loop
The value is 2010BA.NM103 is equal to spaces
The value in 2010BA.NM104 is equal to spaces
The value in 2010BA.NM105 is equal to spaces
The value in 2010BA.NM107 is equal to spaces
The value is 2010BA.NM109 is a HICN (alpha-numeric and not greater than 12 bytes long)
The value in 2010BA.N3 is spaces
The value in 2010BA.N4 is spaces
There is only one iteration of the 2010BB loop per 2000B loop
The value in 2010BB.NM103 is equal to spaces
The value is 2010BB.NM109 is equal to the value in 1000B.NM109
The value in 2010BB.N3 is spaces
The value in 2010BB.N4 is spaces
There are no 2010BD loops
There are no 2000C loops
There is at least one 2300 loop per 2000B loop
There is no more than one hundred (100) 2300 loops per 2000B loop
There is at least one 2320 loop per 2300 loop
At least one iteration of the 2320 loop must have 2320.SBR01 equal to P. Only one iteration of the 2320 loop can have 2320.SBR01 equal to P.
There is only one iteration of the 2330A loop per 2320 loop
There is only one iteration of the 2330B loop per 2320 loop
If there is only one iteration of the 2320 loop (meaning Medicare is the primary payer), the following must be set:
2320.SBR01 is equal to the value of P
2320.SBR02 is equal to the value of 18
2320.SBR05 is equal to the value of MB
2320.SBR09 is equal to the value of MB
2330B.NM108 is equal to the value of PI
2330B.NM109 is equal to the value in 1000A.NM109
At least one iteration of 2330B.REF where:

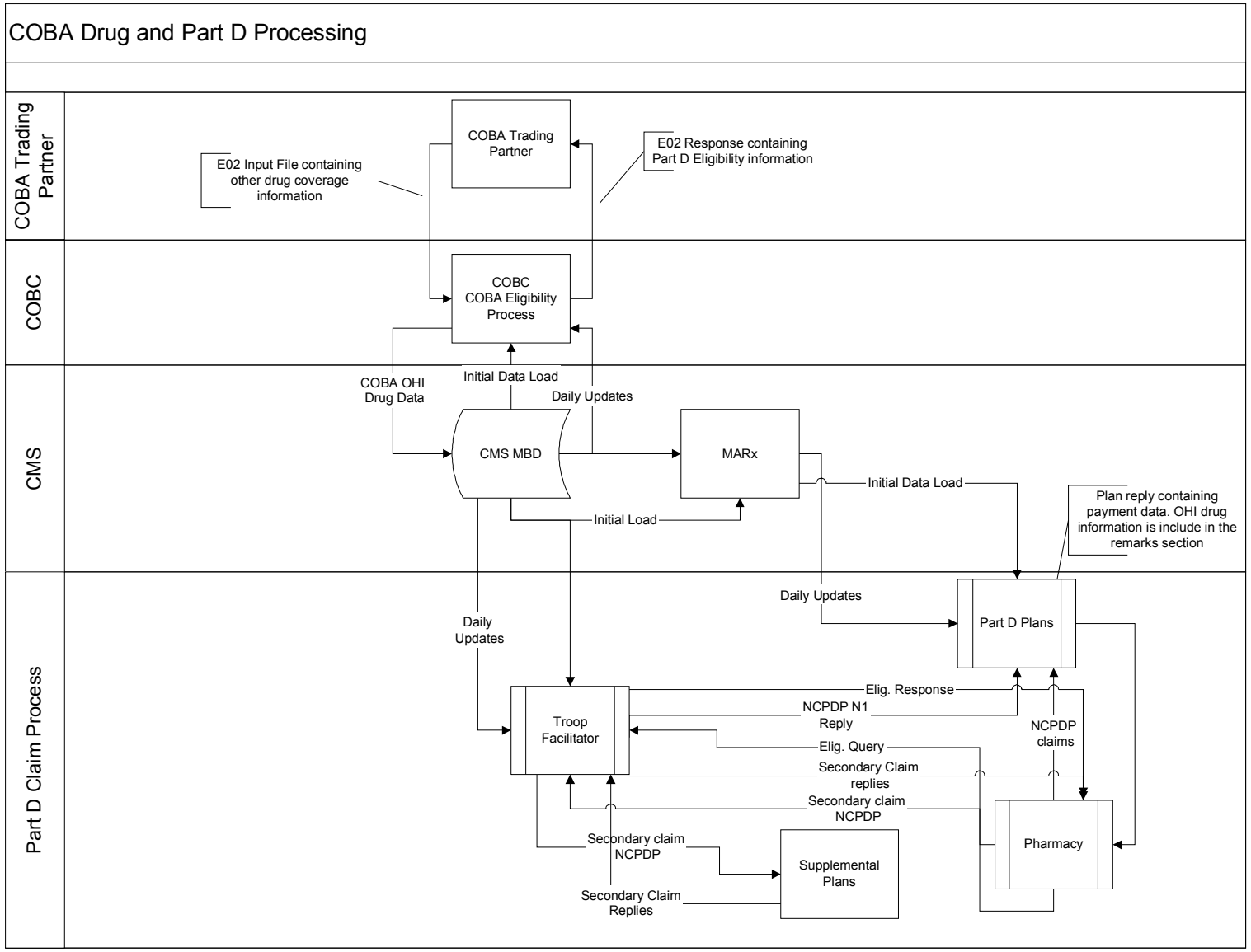
2330B.REF01 is equal to the value of F8
2330B.REF02 is greater than spaces (Carrier or DMERC's claim control number)
For occurrences where 2330B.NM103 is equal to spaces (meaning crossing to another COBA ID), the following must be set:
2330B.NM109 is equal to a valid COBA ID and is not equal to the value in 1000B.NM109
2320.SBR02 is equal to the value of S
There is at least one iteration of the 2400 loop
There is not more than 50 iterations of the 2400 loop per 2300 loop
If there is a 2430 loop, the number of 2430 loops cannot be greater than 25 per 2400 loop.
For the iteration of the 2430 loop (i.e., the Medicare adjudication information), 2430.SVD01 is equal to 2330B.NM109.
Segment SE exists

NCPDP Edits by the COBC

Assumption: DMERCs will forward to compliant NCPDP flat file layout crossover claims files to the
COBC.

1. The Batch Header (B00) exists
2. There is only one Batch Header per B00 – B99 (Batch Trailer) set
3. The value in 880-K1 (Sender ID) in the B00 is a valid DMERC carrier id
4. The value in 880-K7 (Receiver ID) in the B00 is a valid COBA id
5. There is at least one Transaction Header (T00) in the B00 – B99 set
6. There is only one Patient (T01) record per T00 record
7. There is only one Insurance (T04) record per T00 record
8. If the value in 880-K7 in the B00 is a Medigap COBA ID, then the value in 301-C1 (Group ID) in the T04 must be equal to the value in 880-K7
9. There is at least one Claim (T07) record, but no more than 4 T07s per T00
10. For every iteration of a T07 record, there is one Pricing (T11) record
11. For every iteration of the a T07 record, there is one COB/Other Payment (T05) record
12. Within the T05 record, there is at least one occurrence of the COB-INFO
13. If there is only one occurrence of the COB-INFO in the T05, then 338-5C (Other payer coverage type) is equal to 01 and the value in 340-7C (Other payer ID) is equal to 880-K1 of the B00
14. The Batch Trailer (B99) exists 15. There is only one B99 per B00- B99 set

COBA Drug And Part D Processing Flowchart


COBA Drug and Part D Processing
COBA Trading Partner
COBC
CMS
Part D Claim Process
COBA Trading Partner
E02 Input File containing other drug coverage information
E02 Response containing Part D Eligibility information
COBC COBA Eligibility Process
COBA OHI Drug Data
Initial Data Load
Daily Updates
CMS MBD
MARx
Initial Data Load
Initial Load
Plan reply containing payment data. OHI drug information is include in the remarks section
Daily Updates
Daily Updates
Part D Plans
Troop Facilitator
Elig. Response
NCPDP N1 Reply
Elig. Query
Secondary Claim replies
Secondary claim NCPDP
NCPDP claims
Secondary claim NCPDP
Supplemental Plans
Secondary Claim Replies
Pharmacy

CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 83 **Date: MAY 14, 2004**

CHANGE REQUEST 3255

I. SUMMARY OF CHANGES: FIs, carriers, and durable medical equipment regional carriers must notify their trading partners of the attached coordination of benefits companion documents.

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 14, 2004
***IMPLEMENTATION DATE: June 14, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

***Medicare contractors only**

One-Time Notification

Pub. 100-20	Transmittal: 83	Date: May 14, 2004	Change Request 3255

SUBJECT: Additional Health Insurance Health Insurance Portability and Accountability Act (HIPAA) Coordination of Benefits (COB) Information for Trading Partners

I. GENERAL INFORMATION

A. Background: Trading partners need to know how the CMS will develop the HIPAA COB transaction.

B. Policy: The CMS, under HIPAA, is required to develop compliant COB transactions. The Part A and Part B COB, as well as the National Council on Prescription Drug Program (NCPDP) companion documents have been developed to convey CMS's processing intentions where the HIPAA 837 and NCPDP implementation guides are not specific. The CMS desires to clarify to its trading partners what data they may expect from CMS when the conditions listed in the attachments occur. These documents will be referenced in the COB trading partner users' guide, and will be available on CMS's HIPAA Medicare Web site (www.cms.hhs.gov/providers/edi/hipaadoc1.asp). The information included in these guides describes the COB record that CMS will produce as of July 2004 (with the exception of the Part B invalid ICD-9 change which will be changed as of January 3, 2005). In addition, further changes may be made with each quarterly release. When changes are made, CMS will send out another notification and update the companion documents on the website and in the COB trading partner user guide. Note that CMS is making changes effective July 2004. However, non-compliant data may still remain on the claims that are already in process. In most cases, CMS will gap fill at the point when the COB transaction is created. However, there are some instances where CMS cannot make such changes (i.e., CMS cannot make a non-compliant code into a compliant code).

C. Provider Education: None

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3255.1	Contractors shall communicate these COB companion documents to your COB trading partners during your next scheduled notification process or within the next 30 days, whichever is sooner.	FIs, carriers, and durable medical equipment regional carriers (DMERCs)
3255.2	Contractors shall communicate to your COB trading partners that the COB companion documents describe CMS's processing	FIs, carriers, and DMERCs

	intentions where the HIPAA 837 and NCPDP IGs are not specific or where data may not be available to generate HIPAA-compliant outbound COB transactions.	
3255.3	Contractors should add specific items not contained in this companion document. However, these items must not contradict any other items in the companion document or the IGs.	FIs, carriers, and DMERCs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: **June 14, 2004** **Implementation Date:** June 14, 2004 **Pre-Implementation Contact(s):** Matt Klischer, mklischer@cms.hhs.gov, 410-786-7488 **Post-Implementation Contact(s):** Matt Klischer, mklischer@cms.hhs.gov, 410-786-7488	**These instructions should be implemented within your current operating budget.**

3 Attachments

Attachment: National Council for Prescription Drug Program (NCPDP) Coordination of Benefits (COB) Companion Document

Issue	CMS COB Information
Capitalized data	The CMS will format COB data in upper case.
Gap Fill Data	The CMS uses gap fill data that complies with the IG syntax requirements with the understanding that the data may not appear valid. An inbound claim could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound NCPDP transaction. The "gap fill" data meets the data element minimum length requirement of an outbound NCPDP transaction if insufficient data are available for entry in a required data element. The selected values will not include any special characters, low values, high values, or "all spaces" and will be useable with every type of data where this situation could occur (decimal (R), identifier (ID), date (DT), etc.) except for alphanumeric (string) or numeric (Nn). The CMS will use "UNKNOWN" to gap fill alphanumeric data and zeros to gap fill numeric data to meet minimum length requirements. The CMS shall not gap fill data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source.
Medical Code Set Grace Period	The CMS will continue to allow a 90-day grace period for medical code sets for a limited time. The 90-day grace period for ICD9 will end for: - inpatient claims with a discharge date on or after October 1, 2004. - outpatient claims with date of service on or after October 1, 2004. The 90-day grace period for the HCPCS code set will end for claims with dates of service on or after January 1, 2005.
Medicaid	The following field must be submitted in order to allow Medicare to determine that a beneficiary has claim based Medicaid coverage and to specify where the coverage is: - The Group Id (301-C1) on the Insurance segment is not blank. - The two position state alpha code followed by the word "MEDICAID" must be submitted in the Group Id (301- C1) in the Insurance segment. **EXAMPLE: "XXMEDICAID"** such as NYMEDICAID or FLMEDICAID
Medigap	The following fields must be submitted in order to allow Medicare to determine that a beneficiary has Medigap coverage: - The Group Id (301-C1) on the insurance segment is not blank. - For Coordination of Benefits (COB) related to Medigap, the Patients Medigap Plan Id Number will be submitted in the Alternate Id (330-CW) in the Claim segment. - The Medigap Insurer Id (OCNA number) will be submitted in the Group Id (301- C1) in the Insurance segment. **NOTE:** Medigap takes priority when there is dual Medigap and Medicaid in a claim based situation.
Other Payer Amount Paid qualifier field	The NCPDP has approved the following use of qualifiers for reporting Medicare COB amounts: "07" = Medicare Allowed Amount "08" = Medicare Paid Amount "99" = Deductible Amount

Issue	CMS COB Information
	"99" = Coinsurance Amount "99" = Co-Payment Amount **NOTE: The first occurrence of "99" will indicate the Deductible Amount.** The second occurrence of "99" will indicate the Coinsurance Amount. The third occurrence "99" will indicate the Co-Payment Amount.
NCPDP Data	CMS will send out on NCPDP COB, all data that is received on the inbound NCPDP claim regardless as whether Medicare needs the data to process the claim. Any extraneous non-Medicare data will be edited for syntax, but not data content.
Narrative Segment	The NCPDP standard contains a 500-position field in the Prior Authorization Segment that supports one occurrence of narrative information. Medicare COB may contain the following: - Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) - Narrative Supporting Documentation - Facility Name and Address - Modifiers for compound drugs Values for the narrative field that is being used to submit any of the information are as follows. CMN - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information. CNA - Indicates that the supporting documentation that follows is Medicare required CMN or DIF and narrative information. CFA - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information and Facility Name and Address. CNF - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Facility Name and Address. FAC - Indicates that the supporting documentation that follows is Medicare required Facility Name and address. FAN - Indicates that the supporting documentation that follows is Medicare required Facility Name and Address and narrative information. NAR - Indicates that the supporting documentation that follows is Medicare required Narrative Information. MMN - Indicates that the supporting documentation that follows is Medicare modifier information and CMN or DIF information. MNA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information. MFA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and Facility Name and Address. MNF - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Facility Name and Address. MAC - Indicates that the supporting documentation that follows is Medicare modifier information and Facility Name and Address. MAN - Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address. MAR - Indicates that the supporting documentation that follows is Medicare modifier information and narrative information.

Issue	CMS COB Information
	MOD - Indicates that the supporting documentation that follows is Medicare modifier information.

Attachment: Institutional Coordination of Benefits (COB) Companion Document

Issue	CMS's Implementation Guide Interpretation/Resolution
Capitalized data	The CMS will format COB data in upper case.
Value, Occurrence, Occurrence Span, and Condition Codes	Some Codes are defined in the National Code Set as 'payer use only'. The CMS generates these codes via its adjudication process and will allow for these codes to be passed on to the COB even though these codes were not submitted on the inbound claim.
Gap Fill Data	The CMS uses gap fill data that complies with the IG syntax requirements with the understanding that the data may not appear valid. If an inbound claim is could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements needed to prepare and has missing or HIPAA-noncompliant data, a HIPAA-compliant outbound X12N 837 COB transaction. will not be able to be generated. In order to avoid all COB transactions being sent via the standard paper remittance (SPR) process, The "gap fill" data meets the data element minimum length requirement of an outbound X12N 837 COB transaction if insufficient data are available for entry in a required data element. The selected values will not include any special characters, low values, high values, or "all spaces" and will be useable with every type of data where this situation could occur (decimal (R), identifier (ID), date (DT), etc.) except for alphanumeric (string) or numeric (Nn). The CMS will use Xs to gap fill alphanumeric data and 9s to gap fill numeric data. When inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the CMS will gap fill the phone number data element with "8009999999". The CMS shall not gap fill data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source.
Medical Code Set Grace Period	The CMS will continue to allow a 90-day grace period for medical code sets for a limited time. The 90-day grace period for ICD9 will end for: - inpatient claims with a discharge date on or after October 1, 2004. - outpatient claims with date of service on or after October 1, 2004. The 90-day grace period for the HCPCS code set will end for claims with dates of service on or after January 1, 2005.
Should Verses Must Issues	In most instances the CMS interprets the IG 'required when' language to not mean 'reject if submitted when not required'. The CMS interprets the IG to mean the data is allowed even if not required.
Destination Payer verses Other Payer	COB transactions are to contain the payer receiving the claim (the destination payer) in loops 2000B and 2010BC. If the "destination" payer is the same as the "other" payer, the CMS will not populate the 2320 loop. However, there may be instances where the formatting of the payer name is different, even if both payers are actually the same. In these instances the 2320 loop may be created. This issue will be corrected with the implementation of the National PlanID.
Provider/Physician Data	The CMS will allow Attending, Operating, or Other Provider/Physician data to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Patient Status Code	The CMS will allow a patient status code to be sent on COB claims

	whenever it is received on an inbound claim regardless of bill type.
Admitting Diagnosis	The CMS will allow an admitting diagnosis to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Admission Source Code	The CMS will allow an admission source code to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Admission Type Code	The CMS will allow an admission type code to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Discharge Hour	The CMS will allow a discharge hour to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
X12N 997 Acknowledgement	The CMS will not process an incoming X12 997. The CMS contractor may create and use its own proprietary report(s) for feedback purposes.
Health Insurance Prospective Payment System (HIPPS) Rate Codes	The CMS will allow any HIPPS Rate Code (not just skilled nursing facility HIPPS Rate Codes) to be sent on COB claims.
Admission Date/Hour	The CMS will allow admission date/hour data to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Admission Hour/Minute	The CMS will send a default value of "0001" for admission hour/minute for home health claims if the hour/minute is unknown.
CR6 (Home Health)	CMS does not require the CR6 data elements for adjudication of home health claims. Home health claims will be accepted without the CR6 and COB may also be sent without the CR6 for home health claims.
Outpatient Claims	In general, the following bill types are considered outpatient: 13x, 14x – Outpatient Hospital 23x, 24x – SNF 32x, 33x, 34x – Home Health (HHA) 71x – Rural Health Clinic (RHC) 72x – Renal Dialysis Facility (RDF) 73x – Federally Qualified Health Center (FQHC) 74x – Outpatient Rehabilitation Facility (ORF) 75x – Comprehensive Outpatient Rehabilitation Facility (CORF) 76x – Community Mental Health Center (CMHC) 81x, 82x, – Hospice 83x - Hospital Outpatient Surgery Subject to Ambulatory Surgery (ASC) Center Payment Limits 85x – Critical Access Hospital (CAH)
Inpatient Claims	In general, the following bill types are considered inpatient: 11x – Hospital 12x – Inpatient Part B Hospital 18x – Swing Bed 21x – Skilled Nursing Facility (SNF) 22x – Inpatient Part B SNF 41x – Religious Non-Medical Health Care Institution (RNHCI)

ICD-9	The ICD-9-CM procedure codes were named as the HIPAA standard code set for inpatient hospital procedures. The HCPCS/CPT codes were named as the HIPAA standard code set for physician services and other health care services. The Office of HIPAA Standards (OHS) posted an FAQ stating that "…health plans must realize that reporting hospital outpatient services with ICD-9-CM procedure codes on standard claim transactions is not compliant, and that their good faith efforts to come into compliance must include steps being taken to change this requirement." Based on provider and payer input regarding this issue, the CMS has decided not to begin rejecting outpatient claims with ICD-9-CM procedure codes at this time. However, the CMS plans to begin rejecting outpatient claims with ICD-9-CM procedure codes in an upcoming systems release.
TaxID/SSN	When non-HIPAA inbound claims do not contain a required TaxID or SSN, and the CMS does not have a number on file, the CMS will populate the NM109 (Identification Code) with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data to be sent on COB claims.
Provider Address Information	The CMS will populate the outbound COB files with the provider's first name, last name, middle initial, address, city, state and zip code that is present on CMS's provider files.
E-Code Validation	The CMS currently only validates E-codes for claims received via the HIPAA 837 format. E-codes received in other formats (paper, direct data entry, etc.) will be validated in a subsequent CMS release.

ATTACHMENT H

PROVIDER OUTREACH

Medicare Learning Network
Medlearn Matters
Information for Medicare Providers
CMS CENTERS for MEDICARE & MEDICAID SERVICES

Related Change Request (CR) #: N/A **Medlearn Matters Number:** SE0504

Related CR Release Date: N/A

The Centers for Medicare & Medicaid Services (CMS) Consolidation of the Claims Crossover Process

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note that this special edition article is to inform you of system changes to implement a switch from 1) Medicare intermediaries, carriers, and Durable Medical Equipment Regional Carriers (DMERCs) crossing supplemental claims to supplemental insurers to 2) a single entity, the Coordination of Benefits Contractor (COBC), doing the same from one location.

Background

The Centers for Medicare & Medicaid Services (CMS) is consolidating the Medicare claims crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA) initiative.
Currently, **supplemental payers/insurers** (including eligibility-file-based Medigap, Medicaid and employer plans) **must sign multiple crossover agreements** with Part A intermediaries and Part B carriers and Durable Medical Equipment Regional Carriers (DMERCs) to accomplish an automatic, or eligibility-file-based, crossover to other insurers that pay after Medicare has made its payment decision on a claim.
In the future (under the new consolidated claims crossover process) **supplemental payers/insurers will sign one national crossover agreement** and work directly with the COBC (which represents CMS). The supplemental payer/insurer will:
Send eligibility files to identify its covered members, and

Receive outbound HIPAA ANSI X-12N 837 Coordination of Benefits (COB) claims and National Council for Prescription Drug Programs (NCPDP) claims for use in calculating their secondary payment liability.

On July 6, 2004, CMS began testing the consolidated crossover process with approximately ten supplemental payers/insurers. Note the following:

- Testing is focused on the outbound HIPAA ANSI X-12 837N COB claims that are translated from Medicare's Part A intermediary, Part B carrier, and DMERC processed claims.

- Initial -implementation will take place after successful testing is completed, and the 10 supplemental payers/insurers will be moved to full COBA crossover production through one entity, the COBC.
- Throughout the course of fiscal year 2005, CMS will begin transitioning all supplemental payers/insurers from the existing eligibility file-based crossover process to the national COBA process.

Detailed requirements for 1) eligibility file-based crossover and 2) claim-based (mandatory Medigap) crossover were previously issued by CMS in Change Request (CR) 3109 (Transmittal 98), and CMS subsequently issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. Transmittal 138 may be accessed at:
http://www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf
CR 3218 (Transmittal 138) provided:
Major changes to many of the requirements previously published in CR 3109 (Transmittal 98) and

Moved the implementation of claim-based crossover to a future date.

Physician, Provider, and Supplier Action

NOTE: Physicians, providers, and suppliers will not need to take any new actions with respect to the COBA automatic (or eligibility-file-based) crossover process.

The key difference between the existing automatic crossover process and the new COBA automatic crossover process is that, when a supplemental payer/insurer provides CMS with specific claim types and member information for those claims they wish to receive, **the claims will be crossed over to the supplemental payers/insurers only after the claims have left the Medicare claims payment floor.**

Thus, **physician, provider, and supplier offices should receive payment and/or processing information** from a patient's supplemental payer/insurer **after the Medicare payment has been received** (once the supplemental payer/insurer has transitioned to the COBA crossover process). Physicians, providers, and suppliers will be able to reference a listing of eligibility file-based COBA trading partners on the COBA portion of the following CMS COB web site as supplemental payers/insurers are scheduled to move to full eligibility-file-based crossover production under the COBC:
http://www.cms.hhs.gov/medicare/cob/coba/coba.asp.
(This listing is not currently available but will be available after supplemental payers/insurers have moved to full production with the COBC.)

Physicians, providers, and suppliers should note that **the following important information will require your attention when a supplemental payer/insurer 1) has transitioned to the COBA eligibility-file-based crossover process and 2) is listed on the web site noted in the previous paragraph.**

Although the claim may cross to multiple supplemental payers/insurers, only one will print on your remittance advice. In this situation, if one of the supplemental payers/insurers is Medigap, the Medigap insurer will always print.

Since payment from the supplemental payer/insurer should occur only after the Medicare payment has been issued, it is advised that you do not bill the supplemental payer/insurer for a minimum of 15 work days after receiving the Medicare payment. This will allow sufficient time for the claim to cross to the supplemental payer/insurer and the subsequent actions necessary to issue payment from the supplemental payer/insurer.

In addition, prior to submitting a claim to the supplemental payer/insurer, it is advised that you use available self-service tools to research the status of your supplemental payment, e.g., the supplemental payer/insurer's website, claims automated "hot line," etc.

There may be situations (such as claim errors related to HIPAA) that prevent the automatic crossover from occurring after you have received a Medicare remittance advice (electronic or supplemental paper) notifying you that the claim has crossed to the supplemental payer/insurer.

Again, it is advised that you allow a minimum of 15 work days after Medicare payment has been issued before billing the supplemental payer/insurer to ensure that an automatic supplemental payment will not be issued. In addition, it is advised that you use the self-service tools of the supplemental payer/insurer to research the status of your supplemental claim prior to submitting it for supplemental payment.

As a reminder, only the "official" Medicare remittance advice or HIPAA 835 Electronic Remittance Advice should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:

- You are billing the supplemental payer/insurer after the 15 work days from the Medicare- issued payment have expired, and
- You have used the available self-service tools to research the status of your supplemental payment,

Special Note for Physicians and Suppliers

Currently, Part B carriers and DMERCs assign identification numbers (known as In-key or OCNA numbers) to Medigap insurers that do **not** participate in the automatic, or eligibility-file-based, crossover process.

There are no current changes to this process and no current action is required of physicians, providers, and suppliers to change internal procedures related to Medigap claim-based crossovers.

Participating physicians and suppliers that bill Part B carriers and DMERCs for claim-based crossover will be informed approximately 90 days prior to implementing any changes to the claim-based crossover process. CMS expects this method of crossover to decrease sharply under the consolidated COBA crossover process, since most Medigap insurers will now have a single entity to which they can submit eligibility files to identify their covered members.

Related Instructions

On April 9, 2004, CMS issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. CR3218 (Transmittal 138), may be viewed by going to:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp
From that web page, look for CR 3218 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp.

Medlearn Matters
Information for Medicare Providers

Related Change Request (CR) #: 3709 **Medlearn Matters Number: MM3709**
Related CR Release Date: February 11, 2005
Related CR Transmittal #: 474
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

Provider Types Affected

All physicians, providers, and suppliers billing Medicare Fiscal Intermediaries (FIs) and carriers

Provider Action Needed

This instruction includes information contained in Change Request (CR) 3709 which directs MedicareContractors (carriers, intermediaries, and Durable Medical Equipment Regional Carriers [DMERCs]) to issue special automated correspondence from their internal systems to physicians, providers, and suppliers informing them that claims that were expected to be crossed over to supplemental payers/insurers (as indicated on a previous Remittance Advice) were not crossed.

Background

Through the national COBA process, Medicare will automatically cross claims over to a supplemental payer/insurer that may pay after Medicare has made its payment decision on the claim. There may be situations (such as claim errors related to HIPPA) that prevent Medicare from crossing a claim over to thesupplemental payer/insurer.

In those situations where Medicare is unable to cross the claim, CR 3709 directs Medicare Contractors to issue special automated correspondence to notify physicians, suppliers, and providers when claims previously selected for crossover by Medicare were subsequently unable to be crossed to the supplemental payer/insurer.

The correspondence sent to the physician, supplier, or provider will contain specific claim information, including the Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (if the letter is from an intermediary and the claim was for Part A services), Patient Control Number (if present on the claim), beneficiary name, date of service, and the date the claim was processed. In addition, the letter will include the following message:

> "The above claim(s) was/were not crossed over to the patient's supplemental insurer due to claim data errors."

Upon receipt of such correspondence, the physician, supplier, or provider is advised that the claim is not being crossed automatically and the provider may take appropriate action to obtain payment from the supplemental payer/insurer.

Implementation

The implementation date for CR 3709 is July 5, 2005.

Additional Information

Complete details of the COBA Error Notification process are included in the official instruction issued to your carrier/DMERC/intermediary. That instruction may be viewed at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3709 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp

ATTACHMENT I

CONTINGENCY PLAN

COBC Government Programs Business Contingency Plan Overview

Plan Scope: COBC and its Government Programs Division have active Disaster Recovery and Business Contingency programs. The Coordination of Benefits (COB) program at COBC Government Programs is included in the Government Programs Business Contingency Plan (BCP). The COBC Disaster Recovery Plan (DRP) covers the General Support Systems (Mainframe, Distributed Systems, and Voice & Data) that the COB System relies on.

Recovery Sites: COBC utilizes SunGard for its Disaster Recovery site for both Mainframe, Distributed Systems and Voice & Data recovery, and alternate workspace. SunGard provides numerous recovery sites should the primary location be unavailable. Disaster Recovery testing at SunGard facilities is conducted twice a year.

Contingency Planning Methodology: The COBC Government Programs BCP is developed, maintained and tested in accordance with NIST-800 guidelines and the Centers for Medicare & Medicaid Business Partners Systems Security Manual.

Audits: Government Programs conducts a self-assessment annually that includes Service Continuity. COBC Internal Audit conducts an Annual Compliance Audit that included Service Continuity in 2004. Government Programs and COB are also subject to numerous external audits.

Testing: Contingency and DR plans are only reliable if tested. COBC conducts at least two DR tests annually at varying SunGard locations. The COB program participates in at least one of these tests annually. The COB program has participated in the last two DR tests conducted in April and July 2004.

Plan Maintenance: Contingency and DR plans must be kept up to date as businesses and technologies evolve. The COBC Government Programs BCP is updated at least annually and incorporates changes due to DR test results, Business Impact Analysis and Risk Assessments that are conducted.

ATTACHMENT J

AT&T Global Network Service (AGNS) Transmission Resellers

Coordination of Benefits Agreement (COBA) Program
AT&T Global Network Service (AGNS) Transmission Resellers

AGNS is a private network that is capable of transporting multiple protocol data streams to its members at any point in the world. Because the COBC is a member of the AGNS VAN it can talk to other trading partners who are connected to this network. This network service precludes the need to support a separate link to each trading partner, which would be more expensive and difficult to implement and maintain. It is the mandated network to use for COBA related business as directed by the Centers for Medicare & Medicaid Services (CMS). Moreover, AGNS uses an encryption scheme of triple DES as a default to secure the physical transport of transferred data.

Trading partners that do not currently have an existing AGNS account and plan to send and receive crossover information via telecommunications, should contact one or more of the following well-established resellers to obtain a dedicated or a dial-up access line to the managed AGNS VAN. The COBC strongly encourages trading partners to activate new accounts as early as possible to comply with the current technical requirements of the COBA Program.

1. **AAMVA**
   Contact: Henry Majowicz, Network Account Manager
   Phone: 703-908-5761
   Email: Hmajowicz@aamva.org

2. **McKesson**
   Contact: James Boland, Project Manager
   Phone: 404-338-2152
   website: http//www.mckesson.com

3. **IVANS**
   Contact: Tara Mondock, Director Sales
   Phone: 814-235-9082
   Email: Tara.Mondock@IVANS.com
   website: http//www.ivans.com

If you have any technical questions or need further assistance with establishing an electronic transmission link, please contact our Electronic Data Interchange (EDI) Department at (646) 458-6740.

ATTACHMENT K

HELPFUL TECHNICAL INFORMATION

ELIGIBILITY FILES

Effective Date
If the effective date is equal to the cancel date, CMS does not want to see these on the eligibility file. If received, it will be interpreted as one-day of coverage and we will assume this situation was not desired.

Multiple Records
A Trading Partner can send multiple records for a beneficiary under two different Beneficiary Supplement ID Numbers if they are sent in two different eligibility files (e.g. a beneficiary is covered as a spouse under one policy and covered as the contract holder under another policy, both having secondary coverage to Medicare). However, if both numbers are sent on the same eligibility file, it will be treated as a duplicate and will not be accepted.

Location
Trading Partners may submit an eligibility file from a different location, and/or using a different communication method than used for the claim file receipt (i.e., claims are received via NDM and eligibility sent via FTP.)

Date of Birth
The date of birth does not have to be exact. Within date of birth, the month and year must match exactly, but the day can be incorrect.

Multiple Insurers
On the provider hard copy remit (for those that do not get an electronic remit) or the PC Print of the 835, you will see the MA18 on the 835 for eligibility-based crossover and the N89 will be used for multiple insurers.

If the beneficiary has more than one insurance plan and the beneficiary's record is attached to unique COBA IDs, then multiple crossover claims will be created for each COBA ID, per the claims selection criteria specifications in the signed COBA.

If a beneficiary has two or more policies with a single insurance company, and the insurance company has requested that its name be placed on the MSNs and if the beneficiary eligibility records are attached to unique COBA IDs, the MSN would list multiple times that the claim had been crossed over to that particular Trading Partner.

The beneficiary could have policies with multiple insurers that could result in a Trading Partner receiving a Medigap claim from both the intermediary and COBC.

Policy Number
When a policy number changes and this is communicated on the eligibility file, this will be communicated to CWF as an update.

BOI Records
BOI records are transmitted nightly to the CWF based on the eligibility files sent by the Trading Partner. If multiple BOI records exist, all payers will receive the claim.

CWF will maintain a history of up to 40 insurance periods. After 40 BOI records are archived, the earliest record will be deleted with the addition of a subsequent record.

FEP
Your FEP population can be isolated on a separate eligibility file, and can be subject to its own selection criteria.

TECHNICAL REQUIREMENTS

FTP
File transmissions involving the Internet are currently not permissible by CMS. Non-Internet based file transfer protocol options are acceptable to CMS. As Internet options for file transfers are approved, CMS will evaluate more closely the minimum standards for encryption of data exchange as part of the COBA process.

If NDM through AGNS is used, the COBC will use file transfer software, such as FTP, to push the data from the Trading Partner to the COBC and vice-a-versa.

The COBC will advise prospective COBA trading partners of their available electronic connectivity options as part of the process of executing a national COBA. As file transfer connectivity with the trading partner is established, the COBC will pass along its technical requirements for establishing IP addresses for outbound COB files to the COBA trading partner.

CMS is currently evaluating the minimum standards for encryption of outbound data files. Encryption of files may be considered, upon CMS approval, as a future enhancement within the COBA program.

Delimiters
The delimiters are:
Data Element = *
Sub Element Separator = :
Segment Terminator = ~

However, it should be noted that these are subject to change and the current values should be obtained from the ISA segment.

Format
The COBC accommodates transmitting files in an 80 byte wrapped format only.

Translator
The COBC will incorporate the individual files from the Carriers and Fiscal Intermediaries into their daily transmission(s). Files will be run through a pre-edit process, then through a translator and then sorted by COBA IDs for submission as indicated by the trading partners. The COBC's translator will edit to the level of compliance mandated by the HIPAA 837 Implementation Guide. COBC is using the commercial translator GENTRAN.

Provider Instructions
It is CMS' intent for the provider to place the claim-based (Medigap) COBA ID in the other payer ID. It is not expected that the provider will put the eligibility based COBA ID in the other payer ID. If there is an eligibility file-based COBA ID, the Medicare contractors will become aware of this during claims processing and will add the number to the claim for crossover.

CMS will utilize its internal Provider Outreach area as well as Medicare Contractor's Provider Education and Outreach area to inform and educate providers about the COBA program. CMS will also make information about all Trading Partners that participate in eligibility-based versus claim-based crossover under the COBA process available on a designated portion of the COB website at http://www.cms.hhs.gov/medicare/cob/coba/coba.asp.

Providers/physicians/suppliers will be informed about a crossover trading as the result of required HIPAA 835 Electronic Remittance Advice (ERA) specifications. The 835 ERA requires that the name of the entity to which a claim is crossed be present. CWF will return the COBA ID as well as Trading Partner's name via the Beneficiary Other Insurance (BOI) reply trailer (29). Medicare contractors, in turn, will use this information to populate their provider remittance advices and 835 ERA with all required crossover data element, including Trading Partner name.
The fact that the claim was sent to COBC for crossover will be annotated for the provider on the remittance advice.

The new Crossover procedure will not impact pharmacy providers at this time.

CLAIMS FILES

Trading Partners will not receive Claims Files until they execute a COBA since Claims Files contain information that cannot be released without an agreement. Initially, claims will be passed based only on the eligibility file sent by the

Medicare Supplemental payer. Carriers and DMERCs will maintain the responsibility for claim-based crossover until further notice from CMS. When all existing trading partners are transitioned to the COBA process, Medicare carriers and intermediaries will have no need to send COB files to existing trading partners.

The physical file is broken down by ST-SE segment, not by Contractor Identification Number. The Carrier Identification Number is in the 1000A Loop. Claims by individual Trading Partners can be distinguished by COBA IDs that may be referenced in the 1000B loop within the ST-SE envelope. There will be one functional group per ISA to IEA envelope (i.e. one functional group per transmission). The ISA-IEA can contain multiple ST-SE envelopes that can contain up to 5,000 claims per ST-SE envelope. There is no way to limit how many ST to SE's will be in a transaction (ISA to IEA). There will be separate ST-SE groups for each intermediary or carrier.

Trading Partners should not expect separate GS-GE functional groups for each Medicare Intermediary and Carrier. There will be only one GS-GE functional group per transmission (i.e. a single 837 COB file (ISA to IEA.))

Data Elements

The following information will be reported in the data elements:
ISA05 – ZZ
ISA06 (Interchange Sender ID) – COBA
ISA07 and ISA08 – defined by the Trading Partner
GS02 (Application Sender Code) – COBA
GS03 – This will contain the same value as ISA08; whatever the Trading Partner wants in ISA08 will also display here.
NM109 in loop 1000A—CMS contractor-assigned ID
NM109 in loop 1000B—COBA ID
NM109 [NM1 segment] in loop 2010BB (professional)—COBA ID
NM109 [NM1 segment] in loop 2010BC (institutional)—COBA ID
NM109 in loop 2330B—COBA ID (Note: If the Trading Partner referenced in the 2330B loop has executed a COBA, its COBA ID will appear in the NM109 field. If the Trading Partner has not executed a COBA, but does have a crossover agreement directly with a Medicare Intermediary or Carrier, the NM109 field will contain the ID that the Intermediary or Carrier uses to identify that Trading Partner.

Adjusted claims

Adjusted claims can be identified in the Claims Adjustment segment (CAS), as found in the 2320 loop (claim level) and in the 2430 loop (line level), for both the 837 Institutional and Professional Claim.

Multiple Providers with the same Medicare number
The 837 will contain the Contractor ID found in the 1000A Loop, which will result in a unique combination of provider number and Medicare contractor ID.

NM109 of the 2330A Other Subscriber Name loop
If the Trading Partner provides a supplemental insurer ID on the incoming Eligibility File, we will populate the NM109 field of 2330A in the first iteration of the 2320 loop with that value. If no supplemental insurer ID is provided, we will populate it with the HIC number.

EIN
The EIN number cannot be reported for a billing provider in an 837 file (loop 2010AA, NM109) with a leading zero followed by the nine-byte EIN.

The 837P COB files will contain the Medicare carrier's proprietary provider ID for the billing provider in loops 2010AA (billing provider), 2310B (claim level rendering), and 2420A (line level rendering) in REF02 field with a qualifier of 1C.

A unique identifier can be created for ISA 13, Interchange Control Number.
The sender, receiver, creation date and the ISA control number will uniquely identify the generation of the file.

State Licensee Number
The state licensee number will be reported in the 2310A Loop and will not be moved to the 2330D Loop. The 0B qualified REF segment in the 2310A will not be moved.

REF Segment
Medicare will pass along all iterations of the secondary identifier REF segment whether contained in the claim level loops or the COB 2320/2330/2430 Loops if the information comes in on a claim it will be passed to the trading partner. The 0B qualified REF segment in the 2310A will not being moved to the 2330 Loop.

Control Claims Volume
To control the volume of claims file received from the COBC, Trading Partners may split their eligibility records into two separate Eligibility Files using unique COBA Identification Numbers. In addition, the Trading Partner will need to provide the COBC with unique data set names for receipt of separate claims files by COBA ID.

Partial File Rejects
Partial file rejects may be reported to your COBA EDI representative or through the dispute resolution process. Each error will be looked at on an individual

basis. If the problem can be corrected the entire file will be retransmitted. This procedure will apply to all file rejects.

Exclusions

The selection criteria are referenced in Section III of the COBA Attachment. The COBA Attachment can be viewed at http://www.cms.hhs.gov/medicare/cob.

Refer to section IV of the attachment to the COB Agreement for suppression criteria, such as the ability to select specific states to receive electronic claims from.

Choose the type of bill in section IV of the COBA Attachment and exclude all but the Rural Health Clinic.

Section IV D.2 allows for the inclusion/exclusion of DMERC claims by region not by state.

Section IV, Claims Selection Option, E. Common Claim Types

If the Trading Partner exclude #2 on this list (Original Medicare claims paid at 100%), this excludes the Hospital: Inpatient Part A claims that are paid in full by Medicare.

Section IV, Claims Selection Option, E. Common Claim Types, #7

Adjustment claims, non-monetary/statistical is defined as a claim that is modified for the purpose of correcting dates of service and other non-monetary changes but on which the original financial outcome remains unchanged. To exclude any adjusted claims that have changes in the financial outcome, #6 “Adjustment claims, monetary” must be selected.

Section IV, Claims Selection Option, E. Common Claim Types, #6

Adjustment claims, monetary is defined as a claim on which the original financial information, such as the amount - approved or allowed or the amount paid, was modified. To exclude any adjusted claims where Medicare's payment does not change, #7 “Adjustment claims, non-monetary/statistical” must be selected.

One COBA with multiple attachments would facilitate the ability to suppress by state in electing electronic crossovers is critical.

For questions regarding examples of claims that would fall within #10 (National Council for Prescription Drug Programs claims), refer to the NCPDP Web site at www.ncpdp.org.

Testing

CMS and the COBC have tested with all Medicare intermediaries and carriers to validate their ability to produce COB flat files from which COBC can then produce

HIPAA-compliant 837 COB files. That testing has confirmed that these contractors can successfully produce 837 COB flat files.

Parallel test claim files will be provided to the payers by the COBC.

During the testing phase, the COBC will populate “P” for production to the ISA-15.

The COBC will alert all prospective trading partners 60 days in advance of their selection to begin testing the COBA process with the COBC. Considerations such as crossover volume and readiness to test with the COBC in the HIPAA 837 and NCPDP formats will influence where a particular trading partner falls on the transition schedule. The COBC would also be interest in learning about a trading partner’s contingencies that could negatively impact its transition schedule.

By current estimates, all eligibility file-based trading partners should at least be in testing mode by end of fiscal year 2005.

Extensive parallel production testing would mitigate the potential for any problems during implementation.

997 Acknowledgement
COBC will not accept a 997 acknowledgment or negative TA1.

Address
The address on the 837 will be the latest address on the Medicare contractor’s file.

Provider Information
If rendering provider name as well as billing provider information is sent on the claim, the Trading Partner should receive both. If there is an issue/problem with the file size, we cannot rerun the process; only retransmit the entire file again.

HIPAA Format
HIPAA requires all claims be transferred in the ANSI 837 (Professional and Institutional) and the NCPDP. All claims crossed over from the COBC will be in HIPAA compliant format. “Gap filling” will always occur when mandatory fields do not contain values. The Medicare contractors’ system will be responsible for producing “gap filling” on the 837 flat files for crossover.

CMS has no proposed date for lifting the contingency of the 837 outbound format. In the mean time, the COBA process will supersede the existing process.

COBC receives an 837 flat file from the Medicare contractor and then converts it to an outbound HIPAA ANSI X12N (version 4010A1) file.

Depending upon the type of transmission, the Trading Partner may receive only 1 service line per NCPDP claim.

NCPDP
NCPDP claims will be assigned. NCPDP claims do not provide a Medicare Assignment Indicator or Benefits Assignment Indicator. CMS is currently working on a Data Element Request Form (DERF) within the NCPDP to add these data elements.

Audit Trail
Several checks and balances have been instituted into the system to ensure all claims from contractors are accounted for and processed accordingly.

Claims
Well over 1 billion Medicare claims are processed annually. Approximately 600 million of those are crossed over to other payers, including 200 million to Medicaid.

CWF will annotate claims that are to be crossed over. Only these claims will be sent to COBC. The automatic crossover process will continue to be timely. All claims will be forwarded after the Medicare payment has been made. The COBA process standardizes this procedure across all contractors.

Trading Partners will receive claims from all intermediaries, unless they specifically exclude intermediaries by state.

CWF will not allow duplicate denials to be returned to the contractor.

Each claim for service submission request may contain up to four occurrences of claims/service data.

Medicare will enter on the COB for each line item- the Medicare paid amount, any deductible and coinsurance amount applied to the item. Medicare processes claims at the line level.

All Medicare secondary claims are edited for balancing purposes at both the line level and claim level. This is a Medicare function, not a COBA function.

Rail Road Retirement claims are included in this program.

Error reports
Error reports will be sent to inform the Trading Partner that a claim did not crossover. The process does not exist now as to why, but is being considered for a future enhancement.

Crossover
All of the claim records will be triggered by information contained on the eligibility file. It is important that the information on the claim is correct. The key identifier of the eligibility file is the HIC number. During phase I, matching will be based on the HIC number on the claim compared to the HIC number on the eligibility file. In October 2005 (target date) for claim based crossover all mandatory elements and requirements must continue to be met (Mandated Medigap) in order for claims to be crossed over without an eligibility file. For the COBA eligibility-based crossover process, trading partners will receive par and non-par claims. Under the future claim-based crossover process (Mandated Medigap), trading partner will only receive par claims.

Consolidated Claims Files
Trading partners may receive consolidated outbound claims files. There are, however, size limitations for the files. The contractor that processed the claim will be referenced in Loop 1000A. Outbound files can be segregated when there are separate IDs. However, consolidation of the claims file is also available to the trading partner.

Carrier and FI ID
The current Carrier and Fiscal Intermediary Sender ID/Receiver IDs will not be used by the COBC. The COBC will identify the individual Carriers and Fiscal Intermediaries within an 837 claim transmission from the 1000A loop.

Medigap issuers will be able to identify the originating FI or carrier for each claim crossed over by referencing Loop 1000A of the NM109 segment.

Trading Partner/Payer ID
The trading partner/payer receiving the 837 COB file from COBC will be reported in Loop 2330B.

997
The COBC will not accept 997. In place of a 997, the Trading Partner should contact the COBC to discuss the rejections.

MISCELLANEOUS

COBC
Group Health Incorporated is the national COB contractor (COBC). The COBC will sign the agreement on behalf of CMS.

MSP
Although COBC handles Medicare Secondary Process (MSP), the consolidation will not affect the current MSP process.

Implementation
The entire implementation process may span 60-90 business days (including parallel testing). The COBC will work with the Trading Partners to provide a production implementation date for coordination purposes in terminating eligibility-based agreements with Intermediaries and Carriers. The COBC and the Trading Partner will mutually decide when the Trading Partner will make the final step to move to production. Each trading partner will continue to receive production crossover claims via the existing process while testing the COBA process with the COBC.

If a trading partner determines that it cannot meet the specified implementation date to convert to the new COBA consolidated process, the COBC will work with the trading partner to identify a date that would better meet its needs within the established COBA implementation timeline.

Establishment of communications through Connect: Direct (NDM) was estimated at 5 business days. Based on our experiences with our COBA pilot test Trading Partners, in those instances where a Trading Partner already had an existing AGNS and NDM account, connectivity was established in most instances in fewer than 10 business days. Basically, the NDM set-up process amounts to establishing an "IP" address. What drives the timeframe are issues that arise in terms of security on the part of the trading partner as well as the MDCN approval process.

Change Agreement
The 15 day lead time to change a COB Agreement mean that 15 days after the change is requested that it will be operational.

Billing
E-billing is required; however, the trading partner does not have to pay electronically. We envision that E-billing will be used to generate, review, pay, and dispute bills.

The Trading Partner will receive one invoice for each billing location. That invoice could contain multiple COBA IDs.

EDI
The COBC marketing coordinator will contact all existing trading partners regarding testing and implementation.

For questions about multiple COBA ID’s or to escalate any problems with crossover data content if the FI and the secondary payer disagree on the COBA Implementation User Guide interpretation, please contact the EDI department.

Current Trading Partners List

CMS will provide, on the website, a listing of the eligibility based Trading Partners that are in production (http://www.cms.hhs.gov/medicare/cob). Claim based COBA IDs will not be published until July 2005, for implementation in October 2005. Until that time you should continue using your contractor assigned ID.

CMS will require all Trading Partners to eventually utilize the new COBA process. Eventually Medicare Contractors authority to use the current crossover process will be withdrawn.

Agreement

CMS has developed a standard agreement that will be used by all COBA trading partners. Trading Partners will not be able to customize the agreement other than specifying preferences as outlined in the agreement.

Article I.C of the COBA document spells out who is authorized to execute the Trading Partner Agreements.

Only a trading partner can sign agreements. Refer to Section I of the COBA Attachment, which can be viewed at http://www.cms.hhs.gov/medicare/cob, for the definition of who is defined as a trading partner. A third party can sign trading partner agreements directly, only if that third party adjudicates claims for insurers or State Medicaid Agencies.

Trading Partners can designate Trading Partner contractors to perform and support the COBA.

New Trading Partners

Although we will be transitioning current Medicare COB partners in April 2005, there may be a window of opportunity for new trading partners to join the COBA process. The CMS marketing plan allows for three (3) extra slots per month for moving trading partners to the national COBA process.

Terminating Existing Agreements

CMS is currently drafting instructions to all intermediaries and carriers that will give them guidance on relaxing the 90-day termination clause requirement, if necessary.

Trading Partners with an existing agreement will be given priority in the COBC test and transition plan for Supplemental Insurer.